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## DOC VEILLE

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## Assurance maladie / Health Insurance

**Cawley J., Moriya A.S., Simon K. (2013). The impact of the macroeconomy on health insurance coverage: evidence from the great recession.** *Health Economics*, [Ahead of pub]

**Abstract:** This paper investigates the impact of the macroeconomy on the health insurance coverage of Americans using panel data from the Survey of Income and Program Participation for 2004-2010, a period that includes the Great Recession of 2007-2009. We find that a one percentage point increase in the state unemployment rate is associated with a 1.67 percentage point (2.12%) reduction in the probability that men have health insurance; this effect is strongest among college-educated, white, and older (50-64 years old) men. For women and children, health insurance coverage is not significantly correlated with the unemployment rate, which may be the result of public health insurance acting as a social safety net. Compared with the previous recession, the health insurance coverage of men is more sensitive to the unemployment rate, which may be due to the nature of the Great Recession.

**Feigl A.B., Ding E.L. (2013). Evidenced Formal Coverage Index and universal healthcare enactment: A prospective longitudinal study of economic, social, and political predictors of 194 countries.** *Health policy*, 113 (1-2) : 50-60.

**Abstract:** Determinants of universal healthcare (UHC) are poorly empirically understood. We undertook a comprehensive study of UHC development using a novel Evidenced Formal Coverage (EFC) index that combines three key UHC elements: legal framework, population coverage, and accessibility. Applying the EFC index measures (legislation,  $\geq 90\%$  skilled birth attendance,  $\geq 85\%$  formal coverage) to 194 countries, aggregating time-varying data from 1880-2008, this study investigates which macro-economic, political, and social indicators are major longitudinal predictors of developing EFC globally, and in middle-income countries. Overall, 75 of 194 countries implemented legal-text UHC legislation, of which 51 achieved EFC. In a country-year prospective longitudinal analysis of EFC prediction, higher GDP-per-capita (per GDP-per-capita doubling, relative risk [RR]=1.77, 95% CI: 1.49-2.10), higher primary school completion (per +20% completion, RR=2.30, 1.65-3.21), and higher adult literacy were significantly associated with achieving EFC. Results also identify a GDP-per-capita of I\$5000 as a minimum level for development of EFC. GDP-per-capita and education were each robust predictors in middle-income countries, and education remained significant even controlling for time-varying GDP growth. For income-inequality, the GINI coefficient was suggestive in its role in predicting EFC ( $p=0.024$ ). For social and political indicators, a greater degree of ethnic fractionalization (per +25%, RR=0.51, 0.38-0.70), proportional electoral system (RR=2.80, 1.22-6.40), and dictatorships (RR=0.10, 0.05-0.27) were further associated with EFC. The novel EFC index and this longitudinal prospective study together indicate that investment in both economic growth and education should be seen of equal importance for development of UHC. Our findings help in understanding the social and political drivers of universal healthcare, especially for transitioning countries.

## Démographie / Demography

**Emmenegger P., Klemmensen R. (2013). Immigration and redistribution revisited: how different motivations can offset each other.** *Journal of European Social Policy*, 23 (4) : 406-422.

**Abstract:** Despite compelling theoretical arguments, research has failed so far to provide conclusive empirical evidence on the relationship between preferences for redistribution and attitudes towards immigration. We argue that social scientists risk making erroneous inferences if the causal link connecting an independent variable to a given outcome is not carefully modelled. This is particularly true in the presence of multiple and partly offsetting intervening variables. We argue that there are at least four motivations linking attitudes towards redistribution and preferred levels of immigration. We observe a statistically significant association between attitudes towards redistribution and preferred

levels of immigration, but only after the motivations have been explicitly integrated into the empirical analysis. If the motivations are not explicitly modelled, no systematic relationship between attitudes towards redistribution and preferred levels of immigration can be observed.

## Economie de la santé / Health Economics

**Antonanzas F., Rodriguez-Ibeas R. (2013). Channeling health economics research initiatives to improve decision-making processes in the EU. *Eur J Health Econ*, 14 (6) : 847-852.**  
PM:23575665

**Kruger J., Brennan A. (2013). The cost of Type 1 diabetes mellitus in the United Kingdom: a review of cost-of-illness studies. *Eur J Health Econ*, 14 (6) : 887-899.**

**Abstract:** AIMS: To identify cost-of-illness studies of Type 1 diabetes mellitus (Type 1 DM) in the United Kingdom (UK) and review this literature to estimate the current cost of Type 1 DM to the UK National Health Service. METHODS: Bibliographic databases and grey literature were searched systematically to identify all published and unpublished reporting of the costs of Type 1 DM in the UK. Studies were excluded if they did not present cost information from the UK or did not disaggregate information by diabetes type. Three grey literature sources and 11 published studies were identified for inclusion in the literature review. RESULTS: The included studies and reports covered topics including the overall cost of Type 1 DM, costs of individual diabetic complications and costs of specific interventions for Type 1 DM. The most recent published estimate of the cost of Type 1 DM was over 15 years old, and although this estimate has been inflated to current prices the estimate is not adjusted for changes to treatment pathways over this period and is therefore not considered an accurate estimate of current costs of Type 1 DM. CONCLUSIONS: There is no recently published estimate of the cost of Type 1 DM in the UK; therefore, it is recommended that an up-to-date national, comprehensive cost-of-illness study should be conducted. Recommendations for the format of this study are made, including extending the scope to cover recent treatment developments and resource use where diabetes is a subsidiary diagnosis.

**Mou H. (2013). The political economy of the public-private mix in health expenditure: An empirical review of thirteen OECD countries. *Health policy*, [Ahead of pub]**

**Abstract:** This study investigates the factors that may have influenced the public-private mix of health expenditure in 13 OECD countries from 1981 to 2007. The degree to which health services are socialized is regarded as the product of a trade-off between the desire to redistribute income through the fiscal system and the losses some citizens will incur when the public health care system expands. The estimation results show that, greater income inequality and population aging are associated with a smaller share of public health expenditure in total health expenditure. The more ideologically left-leaning the electorate is, the larger the share of public health expenditure. Private health insurance tends to erode the political support for the public health care systems in countries with private duplicate health insurance, but not in countries with private primary health insurance. The findings suggest that the role of private sources of funding for health care is likely to grow in developed countries. The expansion of public coverage to include pharmaceuticals and long-term care in some countries may (theoretically) encounter less opposition if the current insurance holders have no duplicate coverage, if the voters as a whole share more left-leaning political ideology, and if low-income voters are more politically mobilized.

**Tambor M., Pavlova M., Golinowska S., Sowada C., Groot W. (2013). The formal-informal patient payment mix in European countries. Governance, economics, culture or all of these? *Health policy*, [Ahead of pub]**

Abstract: Cost-sharing for health care is high on the policy agenda in many European countries that struggle with deficits in their public budget. However, such policy often meets with public opposition, which might delay or even prevent its implementation. Increased reliance on patient payments may also have adverse equity effects, especially in countries where informal patient payments are widespread. The factors which might influence the presence of both, formal and informal payments can be found in economic, governance and cultural differences between countries. The aim of this paper is to review the formal-informal payment mix in Europe and to outline factors associated with this mix. We use quantitative analyses of macro-data for 35 European countries and a qualitative description of selected country experiences. The results suggest that the presence of obligatory cost-sharing for health care services is associated with governance factors, while informal patient payments are a multi-cause phenomenon. A consensus-based policy, supported by evidence and stakeholders' engagement, might contribute to a more sustainable patient payment policy. In some European countries, the implementation of cost-sharing requires policy actions to reduce other patient payment obligations, including measures to eliminate informal payments.

## Etat de santé / Health Status

**Magnan A., Blanc F.X. (2013). [Personalized medicine for asthma: It's now].** *Rev Mal.Respir.*, 30 (8) : 601-604.

**Quaglio G., Karapiperis T., Van W.L., Arnold E., McDaid D. (2013). Austerity and health in Europe.**, *Health policy* ,113 (1-2) : 13-19.

Abstract: Many European governments have abundantly cut down public expenditure on health during the financial crisis. Consequences of the financial downturn on health outcomes have begun to emerge. This recession has led to an increase in poor health status, raising rates of anxiety and depression among the economically vulnerable. In addition, the incidence of some communicable diseases along with the rate of suicide has increased significantly. The recession has also driven structural reforms, and affected the priority given to public policies. The purpose of this paper is to analyse how austerity impacts health in Europe and better understand the response of European health systems to the financial crisis. The current economic climate, while challenging, presents an opportunity for reforming and restructuring health promotion actions. More innovative approaches to health should be developed by health professionals and by those responsible for health management. In addition, scientists and experts in public health should promote evidence-based approaches to economic and public health recovery by analyzing the present economic downturn and previous crisis. However, it is governance and leadership that will mostly determine how well health systems are prepared to face the crisis and find ways to mitigate its effects.

## Géographie de la santé / Geography of Health

**Vignerot E. (2013). Adapter le système de santé aux territoires d'aujourd'hui et de demain.** *Gestions Hospitalières*, (529)

Abstract: Rupture d'égalité dans l'accès aux soins, état de santé très inégal selon les catégories socioprofessionnelles et les territoires, déserts médicaux, concentration métropolitaine de l'offre, reste à charge, dépassements d'honoraires : tout cela s'est considérablement aggravé au cours des années 2000. Parallèlement, tous les jours apparaissent de nouvelles innovations, de nouveaux progrès techniques.

**Delamater P.L. (2013). Spatial accessibility in suboptimally configured health care systems: A modified two-step floating catchment area (M2SFCA) metric.** *Health & Place*, 24 (0) : 30-43.

Abstract: The floating catchment area (FCA) family of metrics employ principles from gravity-based models to incorporate supply, demand, and distance in their characterization of the spatial accessibility of health care resources. Unlike traditional gravity models, the FCA metrics provide an output in highly interpretable container-like units (e.g., physicians per person). This work explores two significant issues related to FCA metrics. First, the Three Step Floating Catchment Area is critically examined. Next, the research shows that all FCA metrics contain an underlying assumption that supply locations are optimally configured to meet the needs of the population within the system. Because truly optimal configurations are highly unlikely in real-world health care systems, a modified two-step floating catchment area (M2SFCA) metric is offered to address this issue. The M2SFCA is built upon previous FCA metrics, but allows for spatial accessibility to be discounted as a result of the suboptimal configuration of health care facilities within the system. The utility of the new metric is demonstrated through simulated data examples and a case study exploring acute care hospitals in Michigan.

**Ghosn W., Kassie D., Jouglu E., Rican S., Rey G. (2013). Spatial interactions between urban areas and cause-specific mortality differentials in France.** *Health & Place*, 24 (0) : 234-241.

Abstract: Abstract Spatial interactions constitute a challenging but promising approach for investigation of spatial mortality inequalities. Among spatial interactions measures, between-spatial unit migration differentials are a marker of socioeconomic imbalance, but also reflect discrepancies due to other factors. Specifically, this paper asks whether population exchange intensities measure differentials or similarities that are not captured by usual socioeconomic indicators. Urban areas were grouped pairwise by the intensity of connection estimated from a gravity model. The mortality differences for several causes of death were observed to be significantly smaller for strongly connected pairs than for weakly connected pairs even after adjustment on deprivation.

**Learmonth A., Curtis S. (2013). Place shaping to create health and wellbeing using health impact assessment: Health geography applied to develop evidence-based practice.** *Health & Place*, 24 (0) : 20-22.

Abstract: Abstract In a political milieu where there is pressure towards localised and participative decision making, and an environment of global recession and environmental degradation, it is crucial that population health considerations inform strategic decisions. The paper puts forward 'place shaping to create health and wellbeing' as a strategic tool, drawing on ideas that are fundamental in health geography, and argues that this is an important emerging application of Health Impact Assessment (HIA), as part of evidence-based practice. These views developed primarily from case study work in the North East of England aiming to enhance health and wellbeing in a population with significant health disadvantages.

**Mullan F., Chen C., Steinmetz E. (2013). The geography of graduate medical education: imbalances signal need for new distribution policies.** *Health Aff.(Millwood.)*, 32 (11) : 1914-1921.

Abstract: Graduate medical education (GME) determines the overall number, specialization mix, and geographic distribution of the US physician workforce. Medicare GME payments-which represent the largest single public investment in health workforce development-are allocated based on an inflexible system whose rationale, effectiveness, and balance are increasingly being scrutinized. We analyzed Medicare cost reports from teaching hospitals and found large state-level differences in the number of Medicare-sponsored residents per 100,000 population (1.63 in Montana versus 77.13 in New York), total Medicare GME payments (\$1.64 million in Wyoming versus \$2 billion in New York), payments per person (\$1.94 in Montana versus \$103.63 in New York), and average payments per resident (\$63,811 in Louisiana versus \$155,135 in Connecticut). Ways to address these imbalances include revising Medicare's GME funding formulas and protecting those states that receive less Medicare GME support in case funding is decreased and making them a priority if it is increased. The GME system

badly needs a coordinating body to deliberate and make policy about public investments in graduate medical education.

## Hôpital / Hospitals

**Hollue C. (2013). Restructurations hospitalières : quel bilan ?** *Médecins : Bulletin d'Information de l'Ordre National des Médecins*, (31) :

Abstract: Les restructurations hospitalières représentent un bouleversement pour les soignants et sont source d'enjeux politiques et économiques. Elles sont menées avec plus ou moins de réussite et de cohérence. Cet article effectue des regards croisés sur leurs raisons d'être et leurs effets.

[http://www.conseil-national.medecin.fr/sites/default/files/cn\\_bulletin/medecins31\\_1.pdf](http://www.conseil-national.medecin.fr/sites/default/files/cn_bulletin/medecins31_1.pdf)

**Deschamps M. (2013). Tarifs publics / Tarifs privés : l'impossible convergence.** *Revue Hospitalière de France*, (554) :

Abstract: En juin dernier, la Fédération hospitalière de France dressait un bilan d'étape de cette (r)évolution majeure que représente la tarification à l'activité pour les établissements de santé. Après une analyse de leurs ressources, cet article présente le second volet de ce rapport. Les mécanismes de la construction tarifaire et de régulation prix/volume y sont décryptés et commentés, ainsi que le projet de convergence tarifaire intersectorielle, supprimé du projet de loi de financement de la Sécurité sociale 2013. Différences de patientèle, de structure d'activité, de lourdeur des séjours et de contenu médical : tout convergeait vers l'abrogation d'une impossible convergence.

**Asmus-Szepesi K.J.E., de Vreede P.L., Flinterman L.E., Nieboer A.P., Bakker T.J., Borsboom G.J., Mackenbach J.P., Steyerberg E.W. (2013). Prognosis of hospitalised older people with different levels of functioning: a prospective cohort study.** *Age and Ageing*, 42 (6) : 803-809.

Abstract: Background: hospitalised older people are at risk for poor functioning after hospital discharge. We aimed to validate the predictive ability of the Identification Seniors At Risk-Hospitalized Patients (ISAR-HP) screening questionnaire to identify older patients at risk for functional dependence by comparing groups with different ISAR-HP scores on cognitive and physical functioning, mortality, health-related quality of life (HRQoL) and loneliness. Design: a longitudinal prospective cohort study. Setting: a 450-bed hospital in the Netherlands. Subjects: four hundred and sixty patients 65 years or older admitted between June 2010 and October 2010. Methods: participants were classified into five risk groups at hospital admission using the ISAR-HP. We interviewed patients at hospital admission and at 3 and 12 months after admission using validated questionnaires to score HRQoL, physical functioning, cognitive functioning and loneliness. Differences in survival were quantified by a concordance statistic (c). Results: cognitive functioning, physical functioning, loneliness and HRQoL differed significantly between groups during the 1-year follow-up after hospital admission (all comparisons  $P < 0.05$ ), with high-risk groups having lower scores than low-risk groups for functioning and loneliness, although not always for HRQoL. The lowest risk group (ISAR-HP = 0) scored consistently higher on functioning and HRQoL than all other groups. Mortality differed significantly between groups ( $P < 0.001$ ,  $c = 0.67$ ). Conclusions: the ISAR-HP can readily distinguish well-functioning older patients from patients with low functioning and low HRQoL after hospital admission. The ISAR-HP may hence assist in selecting patients who may benefit from individually tailored reactivation treatment that is provided next to treatment of their medical condition.

**Norcini J.J., Boulet J.R., Opalek A., Dauphinee W.D. (2013). Outcomes of Cardiac Surgery: Associations With Physician Characteristics, Institutional Characteristics, and Transfers of Care.** *Medical Care*, 51 (12) :

**Abstract:** Background: Although there are several studies of the human and system factors that influence the outcomes of cardiac surgery, it remains difficult to draw conclusions because many do not simultaneously adjust for the characteristics of patients, physicians, and institutions. The current study explores the associations between these factors and inhospital mortality, with a particular focus on whether patients had the same operating and attending physician. Method and Results: This is a retrospective observational study of 114,751 hospitalizations from 2003 to 2009 in Pennsylvania that included a coronary artery bypass graft, valve surgery, or both. The study included 70 teaching and nonteaching hospitals, 289 operating physicians who were also the attending physicians for 75% of the hospitalizations, and 2654 attending physicians for the remaining hospitalizations. After adjustment, there was a 38.4% decrease (95% CI, 20.3%-56.5%) in mortality when the operating and attending physician were the same. For the operator, each procedure performed was associated with a 0.05% (95% CI, 0.04%-0.06%) decrease in mortality and each year since medical school was associated with a 0.9% (95% CI, 0.02%-1.8%) increase in mortality. For the attending, each year since medical school was associated with a 0.67% (95% CI, 0.01%-1.4%) decrease in patient mortality. Conclusions: The findings indicated that an increase in the log odds of mortality was associated with the transfer of care between an attending and operating physician. Better patient outcomes were associated with an operator with higher volume who was closer to medical school graduation and an attending physician with more clinical experience.

**Duclos A., Polazzi S., Lipsitz S.R., Couray-Targe S., Gawande A.A., Colin C., Berry W., Ayanian J.Z., Carty M.J. (2013). Temporal Variation in Surgical Mortality Within French Hospitals. *Medical Care*, 51 (12)**

**Abstract:** Background: Surgical mortality varies widely across hospitals, but the degree of temporal variation within individual hospitals remains unexplored and may reflect unsafe care. Objectives: To add a longitudinal dimension to large-scale profiling efforts for interpreting surgical mortality variations over time within individual hospitals. Design: Longitudinal analysis of the French nationwide hospital database using statistical process control methodology. Subjects: A total of 9,474,879 inpatient stays linked with open surgery from 2006 through 2010 in 699 hospitals. Measures: For each hospital, a control chart was designed to monitor inpatient mortality within 30 days of admission and mortality trend was determined. Aggregated funnel plots were also used for comparisons across hospitals. Results: Over 20 successive quarters, 52 hospitals (7.4%) experienced the detection of at least 1 potential safety issue reflected by a substantial increase in mortality momentarily. Mortality variation was higher among these institutions compared with other hospitals (7.4 vs. 5.0 small variation signals,  $P < 0.001$ ). Also, over the 5-year period, 119 (17.0%) hospitals reduced and 36 (5.2%) increased their mortality rate. Hospitals with improved outcomes had better control of mortality variation over time than those with deteriorating trends (5.2 vs. 6.3 signals,  $P = 0.04$ ). Funnel plots did not match with hospitals experiencing mortality variations over time. Conclusions: Dynamic monitoring of outcomes within every hospital may detect safety issues earlier than traditional benchmarking and guide efforts to improve the value of surgical care nationwide.

**Tan S.S., Hakkaart-Van-Roijen L., Van Ineveld B.M., Redekop W.K. (2013). Explaining length of stay variation of episodes of care in the Netherlands. *Eur J Health Econ*, 14 (6) : 919-927.**

**Abstract:** OBJECTIVES: Diagnosis Related Group (DRG) systems aim to classify patients into mutually exclusive groups of patients, with the patients in each group having the same expected length of stay (LOS). We examined the ability of current classification variables to explain LOS variation between DRG-like Diagnosis Treatment Combination (DBC)s for ten episodes of care in the Netherlands, including breast cancer, stroke and inguinal hernia repair. Additionally, we assessed the predictive ability of some other classification variables. METHODS: For each episode of care, the relevant DBC codes of all hospitalizations in 2008 were identified and all available determinants that may serve as classification variables were acquired from the national database. Ordinary least squares regression was used to examine the predictive ability of these classification variables. RESULTS: The current classification variables are not sufficiently distinct to classify patients into mutually exclusive groups of patients. ICU admissions and hospital type may serve as valuable classification variables. Additionally, episode-specific variables may improve the Dutch grouping algorithm. CONCLUSIONS: Although it may not be feasible in the short term, grouping algorithms

would benefit greatly from the introduction of classification variables tailored to the needs of specific episodes of care. A first step would be to focus on 'general' classification variables meaningful for specific episodes of care.

**Mitropoulos P., Mitropoulos I., Sissouras A. (2013). Managing for efficiency in health care: the case of Greek public hospitals. *Eur J Health Econ*, 14 (6) : 929-938**

Abstract: This paper evaluates the efficiency of public hospitals with two alternative conceptual models. One model targets resource usage directly to assess production efficiency, while the other model incorporates financial results to assess economic efficiency. Performance analysis of these models was conducted in two stages. In stage one, we utilized data envelopment analysis to obtain the efficiency score of each hospital, while in stage two we took into account the influence of the operational environment on efficiency by regressing those scores on explanatory variables that concern the performance of hospital services. We applied these methods to evaluate 96 general hospitals in the Greek national health system. The results indicate that, although the average efficiency scores in both models have remained relatively stable compared to past assessments, internal changes in hospital performances do exist. This study provides a clear framework for policy implications to increase the overall efficiency of general hospitals.

**Kounetas K., Papathanassopoulos F. (2013). How efficient are Greek hospitals? A case study using a double bootstrap DEA approach. *Eur J Health Econ*, 14 (6) : 979-994.**

Abstract: The purpose of this study was to measure Greek hospital performance using different input-output combinations, and to identify the factors that influence their efficiency thus providing policy makers with valuable input for the decision-making process. Using a unique dataset, we estimated the productive efficiency of each hospital through a bootstrapped data envelopment analysis (DEA) approach. In a second stage, we explored, using a bootstrapped truncated regression, the impact of environmental factors on hospitals' technical and scale efficiency. Our results reveal that over 80 % of the examined hospitals appear to have a technical efficiency lower than 0.8, while the majority appear to be scale efficient. Moreover, efficiency performance differed with inclusion of medical examinations as an additional variable. On the other hand, bed occupancy ratio appeared to affect both technical and scale efficiency in a rather interesting way, while the adoption of advanced medical equipment and the type of hospital improves scale and technical efficiency, correspondingly. The findings of this study on Greek hospitals' performance are not encouraging. Furthermore, our results raise questions regarding the number of hospitals that should operate, and which type of hospital is more efficient. Finally, the results indicate the role of medical equipment in performance, confirming its misallocation in healthcare expenditure.

**Holmas T.H., Kamrul I.M., Kjerstad E. (2013). Between two beds: inappropriately delayed discharges from hospitals. *Int J Health Care Finance Econ* Epub ahead of print]**

Abstract: Acknowledging the necessity of a division of labour between hospitals and social care services regarding treatment and care of patients with chronic and complex conditions, is to acknowledge the potential conflict of interests between health care providers. A potentially important conflict is that hospitals prefer comparatively short length of stay (LOS) at hospital, while social care services prefer longer LOS all else equal. Furthermore, inappropriately delayed discharges from hospital, i.e. bed blocking, is costly for society. Our aim is to discuss which factors that may influence bed blocking and to quantify bed blocking costs using individual Norwegian patient data, merged with social care and hospital data. The data allow us to divide hospital LOS into length of appropriate stay (LAS) and length of delay (LOD), the bed blocking period. We find that additional resources allocated to social care services contribute to shorten LOD indicating that social care services may exploit hospital resources as a buffer for insufficient capacity. LAS increases as medical complexity increases indicating hospitals incentives to reduce LOS are softened by considerations related to patients' medical needs. Bed blocking costs constitute a relatively large share of the total costs of inpatient care.

**Cheng A.H., Sutherland J.M. (2013). British Columbia's pay-for-performance experiment: Part of the solution to reduce emergency department crowding? *Health policy (Amsterdam, Netherlands)*, 113 (1-2) : 86-92.**

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**Abstract:** BACKGROUND: Emergency department (ED) overcrowding continues to be a well-publicized problem in a number of countries. In British Columbia, a province in Canada, an ED pay-for-performance (ED P4P) program was initiated in 2007 to create financial incentives for hospitals to reduce patients' ED length of stay (ED LOS). This study's objectives are to determine if the ED P4P program is associated with decreases in ED LOS, and to address the ED P4P program's limitations. METHODS: We analyze monthly hospital-level ED LOS time data since the inception of the financial incentives. Since the ED P4P program was phased in at different hospitals from different health authorities over time, hospitals' data from only two regional health authorities are included in the study. RESULTS: We find association between the implementation of ED P4P and ED LOS time data. However, due to the lack of control data, the findings cannot demonstrate causality. Furthermore, our findings are from hospitals in the greater Vancouver area only. INTERPRETATION: BC's ED P4P was introduced to create incentives for hospitals to reduce ED LOS by providing incremental incentive funding. Available data indicate that the ED P4P program is associated with mixed successes in reducing ED LOS among participating hospitals.

**Solans-Domenech M., Adam P., Tebe C., Espallargues M. (2013). Developing a universal tool for the prioritization of patients waiting for elective surgery. *Health policy*, 113 (1-2) : 118-126.**

**Abstract:** The objective was to elaborate a priority scoring system for patients on waiting lists for elective surgery to be implemented in the Catalan public health system. This tool should ideally be universal (for all patients and across the entire region) with common criteria and weights (for all surgical procedures), simple and user-friendly. A tool based on a point-count linear scale ranging from 0 (lowest priority) to 100 (highest priority) was developed. Patients are scored in three major dimensions: clinical and functional impairment, expected benefit, and social role, which include 8 criteria (with their weights): disease severity (23%), pain (or other main symptoms) (14%), rate of disease progression (15%), difficulty in doing activities of daily life (14%), probability and degree of improvement (12%), being dependent with no caregiver (5%), limitation to care for one's dependents (if that be the case) (8%), and limitations in the ability to work, study or seek for employment (9%). As in previous studies developed in Canada, New Zealand and Catalonia, the tool obtained is mainly based on severity and need. The success of this tool depends very much on implementation mechanisms. Furthermore, prior to implementation, a definition of specificities in the selected criteria for the most frequent surgical procedures is advised.

**Schut F.T., Varkevisser M. (2013). Tackling hospital waiting times: The impact of past and current policies in the Netherlands. *Health policy*, 113 (1-2) : 127-133.**

**Abstract:** This paper reviews the impact of health policies on hospital waiting times in the Netherlands over the last two decades. During the 1990s hospital waiting times increased as a result of the introduction of fixed budgets and capacity constraints for specialists, in addition to the fixed global hospital budgets that were already in place since the 1980s. To tackle these increased waiting times over the years 2000-2011 several policies were implemented, including a change from fixed budgets to activity-based funding - for both hospitals and specialists - and increased competition among hospitals. All together these measures resulted in a strong reduction of waiting times. In 2011 mean expected waiting times for almost all surgical procedures varied from 2 to 6 weeks, well below the broadly accepted specified maximum waiting times. Hence, in the Netherlands hospital waiting times are currently not an important policy concern. Since the waiting time reduction was achieved at the expense of rapidly growing hospital costs, these have become now the primary policy concern. This has triggered the introduction of new powerful supply-side constraints in 2012, which may cause waiting times to increase for the coming years.

**Heijink R., Mosca I., Westert G. (2013). Effects of regulated competition on key outcomes of care: Cataract surgeries in the Netherlands. *Health policy*, 113 (1-2) : 142-150.**

**Abstract:** Similar to several other countries, the Netherlands implemented market-oriented health care reforms in recent years. Previous studies raised questions on the effects of these reforms on key outcomes such as quality, costs, and prices. The empirical evidence is up to now mixed. This study looked at the variation in prices, volume, and quality of cataract surgeries since the introduction of price competition in 2006. We found no price convergence over time and constant price differences



between hospitals. Quality indicators generally showed positive results in cataract care, though the quality and scope of the indicators was suboptimal at this stage. Furthermore, we found limited between-hospital variation in quality and there was no clear-cut relation between prices and quality. Volume of cataract care strongly increased in the period studied. These findings indicate that health insurers may not have been able to drive prices down, make trade-offs between price and quality, and selectively contract health care without usable quality information. Positive results coming out from the 2006 reform should not be taken for granted. Looking forward, future research on similar topics and with newer data should clarify the extent to which these findings can be generalized.

## Inégalités de santé / Health Inequalities

**Hudson D.L., Puterman E., Bibbins-Domingo K., Matthews K.A., Adler N.E. (2013). Race, life course socioeconomic position, racial discrimination, depressive symptoms and self-rated health. *Social Science & Medicine*, 97 (0) : 7-14.**

**Abstract:** Greater levels of socioeconomic position (SEP) are generally associated with better health. However results from previous studies vary across race/ethnicity and health outcomes. Further, the majority of previous studies do not account for the effects of life course SEP on health nor the effects of racial discrimination, which could moderate the effects of SEP on health. Using data from the Coronary Artery Risk Development in Young Adults (CARDIA) study, we examined the relationship between a life course SEP measure on depressive symptoms and self-rated health. A life course SEP was constructed for each participant, using a framework that included parental education and occupation along with respondents' highest level of education and occupation. Interaction terms were created between life course SEP and racial discrimination to determine whether the association between SEP and health was moderated by experiences of racial discrimination. Analyses revealed that higher levels of life course SEP were inversely related to depressive symptoms. Greater life course SEP was positively associated with favorable self-rated health. Racial discrimination was associated with more depressive symptoms and poorer self-rated health. Analyses indicated a significant interaction between life course SEP and racial discrimination on depressive symptoms in the full sample. This suggested that for respondents with greater levels of SEP, racial discrimination was associated with reports of more depressive symptoms. Future research efforts should be made to examine whether individuals' perceptions and experiences of racial discrimination at the interpersonal and structural levels limits their ability to acquire human capital as well as their advancement in education and occupational status.

**Baeten S., Van Ourti T., Van Doorslaer E. (2013). The socioeconomic health gradient across the life cycle: What role for selective mortality and institutionalization? *Social Science & Medicine*, 97 (0) : 66-74.**

**Abstract:** Several studies have documented the now fairly stylized fact that health inequalities by income differ across the age distribution: in cross-sections the health gap between rich and poor tends to widen until about age 50 and then declines at higher ages. It has been suggested that selective mortality and institutionalization could be important factors driving the convergence at higher ages. We use eight waves of a health survey linked to four registries (on mortality, hospitalizations, (municipal) residence status and taxable incomes) to test this hypothesis. We construct life cycle profiles of health for birth year/gender/income groups from the health surveys (based on 128,689 observations) and exploit the registries to obtain precise estimates of individual probabilities of mortality and institutionalization using a seven year observation period for 2,521,122 individuals. We generate selection corrected health profiles using an inverse probability weighting procedure and find that attrition is indeed not random: older, poorer and unhealthier individuals are significantly more likely not to survive the next year and to be admitted to an institution. While these selection effects are very significant, they are not very large. We therefore reject the hypothesis that selective dropout is an important determinant of the differential health trajectories by income over the life course in the Netherlands.

**Eriksson M., Emmelin M. (2013). What constitutes a health-enabling neighborhood? A grounded theory situational analysis addressing the significance of social capital and gender.** *Social Science & Medicine*, 97 (0) : 112-123.

**Abstract:** Abstract Variations in health between neighborhoods are well known and the conceptualization of social capital has contributed to an understanding of how contextual factors influence these differences. Studies show positive health-effects from living in high social capital areas, at least for some population sub-groups. The aim of this qualitative study was to understand what constitutes a health-enabling's neighborhood. It follows up results from a social capital survey in northern Sweden indicating that the health effects of living in a high social capital neighborhood is gendered in favor of women. A grounded theory situational analysis of eight focus group discussions - four with men and four with women- illustrated similar and different positions on how neighborhood characteristics influence health. A neighborhood, where people say hi to each other factor and where support between neighbors exist, were factors perceived as positive for health by all, as was a good location, neighborhood greenness and proximity to essential arenas. Women perceived freedom from demands, feeling safe and city life as additional health enabling factors. For men freedom to do what you want, a sense of belonging, and countryside life were important. To have burdensome neighbors, physical disturbances and a densely living environment were perceived as negative for health in both groups while demands for a well styled home and feeling unsafe were perceived as negative for health among women. Neighborhood social capital, together with other elements in the living environment, has fundamental influence on people's perceived health. Our findings do not confirm that social capital is more important for women than for men but that distinctive form of social capital differ in impact. Investing in physical interventions, such as planning for meeting places, constructing attractive green areas, and making neighborhoods walking-friendly, may increase human interactions that is instrumental for social capital and is likely to have health promoting effects for all.

**Shaw B.A., McGeever K., Grubert E., Agahi N., Fors S. (2013). Socioeconomic inequalities in health after age 50: Are health risk behaviors to blame?** *Social Science & Medicine*, (Ahead of pub) :

**Abstract:** Abstract Recent studies indicate that socioeconomic inequalities in health extend into the elderly population, even within the most highly developed welfare states. One potential explanation for socioeconomic inequalities in health focuses on the role of health behaviors, but little is known about the degree to which health behaviors account for health inequalities among older adults, in particular. Using data from the Health and Retirement Study (N=19,245), this study examined the degree to which four behavioral risk factors : smoking, obesity, physical inactivity, and heavy drinking - are associated with socioeconomic position among adults aged 51 and older, and whether these behaviors mediate socioeconomic differences in mortality, and the onset of disability among those who were disability-free at baseline, over a 10-year period from 1998-2008. Results indicate that the odds of both smoking and physical inactivity are higher among persons with lower wealth, with similar stratification in obesity, but primarily among women. The odds of heavy drinking decrease at lower levels of wealth. Significant socioeconomic inequalities in mortality and disability onset are apparent among older men and women; however, the role that health behaviors play in accounting for these inequalities differs by age and gender. For example, these health behaviors account for between 23-45% of the mortality disparities among men and middle aged women, but only about 5% of the disparities found among women over 65 years. Meanwhile, these health behaviors appear to account for about 33% of the disparities in disability onset found among women survivors, and about 9-14% among men survivors. These findings suggest that within the U.S. elderly population, behavioral risks such as smoking and physical inactivity contribute moderately to maintaining socioeconomic inequalities in health. As such, promoting healthier lifestyles among the socioeconomically disadvantaged older adults should help to reduce later life health inequalities.

**McCartney G., Collins C., Mackenzie M. (2013). What (or who) causes health inequalities: Theories, evidence and implications?** *Health policy*, 113(3):221-

**Abstract:** Health inequalities are the unjust differences in health between groups of people occupying different positions in society. Since the Black Report of 1980 there has been considerable effort to understand what causes them, so as to be able to identify actions to reduce them. This paper revisits and updates the proposed theories, evaluates the evidence in light of subsequent epidemiological

research, and underlines the political and policy ramifications. The Black Report suggested four theories (artefact, selection, behavioural/cultural and structural) as to the root causes of health inequalities and suggested that structural theory provided the best explanation. These theories have since been elaborated to include intelligence and meritocracy as part of selection theory. However, the epidemiological evidence relating to the proposed causal pathways does not support these newer elaborations. They may provide partial explanations or insights into the mechanisms between cause and effect, but structural theory remains the best explanation as to the fundamental causes of health inequalities. The paper draws out the vitally important political and policy implications of this assessment. Health inequalities cannot be expected to reduce substantially as a result of policy aimed at changing health behaviours, particularly in the face of wider public policy that militates against reducing underlying social inequalities. Furthermore, political rhetoric about the need for 'cultural change', without the required changes in the distribution of power, income, wealth, or in the regulatory frameworks in society, is likely to divert from necessary action.

**Tallarek Nee Grimm M.J., Helgesen M.K., Fosse E. (2013). Reducing social inequities in health in Norway: Concerted action at state and local levels? *Health policy?* 2013 113(3):228-235**

Abstract: Norwegian national policies have been distinguished by their focus on equity, contributing to comprehensive policies to reduce the social inequities in health (SIH). The newly adopted Public health act, which aims at reducing the SIH, endorses these acknowledgements while highlighting the importance of municipalities as the key actors in public health. Municipal obligations include inter-sectoral policies for health, health impact assessments (HIA), and the development of local health overviews. Against the background of a system of local autonomy in Norway, this article illuminates whether, and how, municipal public health policies reflect national priorities. Our data are based on one qualitative study, combining document content analysis and expert interviews conducted in 2011, and one quantitative questionnaire sent to municipal chief administrative officers in 2011. Our findings indicate a divide between national and municipal public health strategies. Many municipalities focus on life-style and health-care related measures. Only few municipalities acknowledge the social determinants of health and have implemented HIA and health overviews. Arguing for the importance of concerted multi-level action to reduce the SIH, we need to better understand the gap between national and municipal approaches. We thus suggest further research to illuminate the challenges and success factors faced at local levels.

## Médicaments / Pharmaceuticals

**(2013). Médicaments sous "surveillance supplémentaire" : un triangle noir européen.** *Revue Prescrire*, 33 (361) :

Abstract: Mi-2013 dans l'Union européenne, une liste d'une centaine de médicaments, présentés comme faisant l'objet d'une "surveillance supplémentaire" par les autorités de santé, a été rendue publique. L'apposition d'un triangle noir "inversé" (c'est-à-dire pointé vers le bas) dans leurs résumés des caractéristiques (RCP) et sur leur notice, mais pas sur les boîtes, vise à les rendre identifiables par les professionnels de santé et les patients, et à stimuler la déclaration des effets indésirables.

**(2013). Conflits d'intérêts : une réforme molle.** *Revue Prescrire*, 33 (361)

Abstract: Dans le cadre du procès Mediator, des responsables de l'Agence française du médicament ont été mise en examen pour "prise illégale d'intérêts et autre participation illégale d'un fonctionnaire dans une entreprise précédemment contrôlée (Servier). Pourtant, en 2013, il semble toujours impossible pour les pouvoirs publics de changer les règles du jeu dans les agences comme le montre la charte de l'expertise sanitaire (décret n° 2013-413 du 21 mai 2013).

**(2013). Génériques : raison garder.** *Revue Prescrire*, 33 (361) :

Abstract: Une fois que toutes les mesures de protection (brevet, etc) d'une spécialité pharmaceutique princeps, alias princeps, ont expiré, ce médicament peut être copié. On parle alors des spécialités génériques, alias génériques. Les génériques ne sont pas une exception française. Leurs caractéristiques et leur qualité pharmaceutique sont encadrées par des normes internationales. Mais des polémiques sur une moindre efficacité ou une moindre qualité des génériques sont nombreuses, non fondées et parfois orchestrées par les firmes pharmaceutiques. Tel est le sujet abordé dans cet article.

**Mao W., Tang S., Chen W. (2013). Does perverse economic incentive lead to the irrational uses of medicines?.** *Expert Review of Pharmacoeconomics & Outcomes Research*, 13 (6) : 693-696.

**Kalo Z., Annemans L., Arrison L.P. (2013). Differential pricing of new pharmaceuticals in lower income European countries.** *Expert Review of Pharmacoeconomics & Outcomes Research*, 13 (6) : 735-741.

**Milos V., Jakobsson U., Westerlund T., Melander E., et al. (2013). Theory-based interventions to reduce prescription of antibiotics : randomized controlled trial in Sweden.** *Family Practice*, 30 (6) : 634-640.

Abstract: Background. Upper respiratory tract infections (URTIs) are the most common reason for consulting a GP and for receiving an antibiotic prescription, although evidence shows poor benefit but rather increasing antibiotic resistance. Interventions addressing physicians have to take into consideration the complexity of prescribing behaviour. Objective. To study whether interventions based on behavioural theories can reduce the prescribing of antibiotics against URTIs in primary care. Setting and subjects. GPs at 19 public primary health care centres in southern Sweden. Methods. We performed a randomized controlled study using two behavioural theory-based interventions, the persuasive communication intervention (PCI) and the graded task intervention (GTI), which emerged from social cognitive theory and operant learning theory. GPs were randomized to a control group or one of two intervention groups (PCI and GTI). Main outcome measures. Changes in the rate of prescription of antibiotics against URTIs in primary care patients of all ages and in patients aged 0-6 years. Results. No significant differences were seen in the prescription rates before and after the interventions when patients of all ages were analysed together. However, for patients aged 0-6 years, there was a significant lower prescription rate in the PCI group (P = 0.037), but not the GTI group, after intervention. Conclusion. Theory-based interventions have limited impact on reducing the prescription of antibiotics against URTIs in primary care. Future studies are needed to draw firm conclusions about their effects.

**Li S., Laxminarayan R. (2013). Are physicians' prescribing decisions sensitive to drug prices? Evidence from a free-antibiotics program.** *Health Econ*, [Epub ahead of print]

Abstract: This paper investigates whether patient-level factors, in particular cost considerations, affect the physicians' prescribing decisions. In the context of a natural experiment, we examine the effect of the first US commercial free-antibiotics program on retail antibiotic sales. We find an overall increase in antibiotic prescriptions under the program and substitutions to covered antibiotics from not-covered antibiotics. The shift away from not-covered antibiotics, particularly from those without covered equivalents, indicates a change in the physicians' prescribing decisions. We locate stronger program effects in low-income areas. Our findings, robust to a variety of specifications, are in contrast with previous literature.

**Leopold C., Mantel-Teeuwisse A.K., Vogler S., de J.K., Laing R.O., Leufkens H.G. (2013). Is Europe still heading to a common price level for on-patent medicines? An exploratory study among 15 Western European countries.** *Health policy*, 112 (3) : 209-216.

Abstract: BACKGROUND: Previous studies have suggested that medicines prices in Europe converge over time as a result of policy measures such as external price referencing. OBJECTIVE: To explore whether ex-factory prices of on-patented medicines in Western European countries have converged over a recent period of time. METHODS: Prices of ten on-patent medicines in five years (2007, 2008,

2010, 2011, 2012) of 15 European countries were analyzed. The unit of analysis was the ex-factory price in Euro per defined daily dose (exchange rate indexed to 2007). A score (deviation from the average price) per country as well as the ranges were calculated for all medicines. RESULTS: The prices between countries and selected products varied to a great extent from as low as an average price of euro1.3/DDD for sitagliptin in 2010-2012 to an average of euro221.5/DDD for alemtuzumab in 2011. Between 2008 and 2012, a price divergence was seen which was fully driven by two countries, Germany (up to 27% more expensive than the average) and Greece (up to 32% cheaper than the average). All other countries had stable prices and centered around the country average. Prices of less expensive as well as expensive medicines remained relatively stable or decreased over time, while only the price of sirolimus relatively increased. CONCLUSIONS: Our study period included the time of the recession and several pricing policy measures may have affected the prices of medicines. Instead of the expected price convergence we observed a price divergence driven by price changes in only two of the 15 countries. All other European countries remained stable around the country average. Further research is needed to expand the study to a bigger sample size, and include prescribing data and Eastern European countries.

**Jommi C., Costa E., Michelon A., Pisacane M., Scroccaro G. (2013). Multi-tier drugs assessment in a decentralised health care system. The Italian case-study. *Health policy* 112 (3) : 241-247.**

Abstract: OBJECTIVE: To investigate the organisation and decision-making processes of regional and local therapeutic committees in Italy, as a case-study of decentralised health care systems. METHODS: A structured questionnaire was designed, validated, and self-administered to respondents. Committee members, prioritisation, assessment process and criteria, and transparency of committees were investigated. RESULTS: The respondents represent 100% of the 17 regional committees out of 21 regions (in 4 regions there is not any regional formulary), 88% of the 16 hospital networks and 42% of the 183 public hospitals. The assessment process appears fragmented and may take a long time: drugs inclusion into hospital formularies requires two steps in most regions (regional and local assessment). Most of the therapeutic committees are closed to industry and patients associations involvement. Prioritisation in the assessment is mostly driven by disease severity, clinical evidence, and the absence of therapeutic alternatives. Only 13 out of the 17 regional committees have a public application form for drugs inclusion into regional formulary. Regional and local committees (i) often re-assess the clinical evidence already evaluated at central level and (ii) mostly rely on comparative drug unit prices per DDD and drug budget impact. The level of transparency is quite low. CONCLUSIONS: The Italian case-study provides useful insights into an appropriate management of multi-tier drugs assessment, which is particularly complex in decentralised health care systems, but exists also in centralised systems where drugs are assessed by local therapeutic committees. A clear definition of regulatory competences at different levels, a higher collaboration between central, regional and local actors, and increased transparency are necessary to pursue consistency between central policies on price and reimbursement and budget accountability at the regional and local levels.

**Maison P., Zanetti L., Solesse A., Bouvenot G., Massol J. (2013). The public health benefit of medicines: How it has been assessed in France? The principles and results of five years' experience. *Health policy*, 112 (3) : 273-284.**

Abstract: Health technology assessment seeks to inform health policy- and decision-makers by promoting use of current best evidence and by addressing country specific factors, such as local context and values. In France, public health benefit (PHB) is one of the criteria used to inform decisions on the reimbursement of medicines. This article describes the methodological framework and the results after five years of assessment of PHB, by the French National Authority for Health. The semi-quantitative method used includes three dimensions that are: (1) the ability of a drug to improve the population's health status, (2) the drug's adequacy to cover public health needs, and; (3) the impact of the drug on the healthcare system. From 2005 to 2010, the PHB of 530 drugs was estimated, and 72% were assessed as having no PHB. The PHB was "low" for 88% of drugs expected to have a PHB, "medium" for 10%, and was considered to be "high" in only one case. The results of this experience show that it is feasible to assess the public health impact of drugs. But the high level of uncertainties at the time of a drug's first appraisal limits the assessment, which obviously has to be completed by reappraisal with post-marketing studies.

**Holbrook A., Lexchin J., Pullenayegum E., Campbell C., Marlow B., Troyan S., Weijer C., Blackmer J., Brazil K., Willison D. (2013). What do Canadians think about physician and pharmaceutical industry interactions? *Health policy*, 112 (3) : 255-263.**

**Abstract:** Background Many health professional and regulatory groups have guidelines for identifying, disclosing and managing potential conflicts of interest (COI). The opinions of the Canadian public regarding what constitutes COI are unknown. Methods: Bilingual telephone survey in all provinces using a validated questionnaire on public opinions on physician's pharmaceutical industry interactions (POPPII). Adults 18 years or older were contacted using random digit dialing (RDD) with representative national sampling of households. Results were analyzed for predictors of opinions and were compared with the reference COI guideline. Two follow-up focus groups were held. Results 1041 participants (56.8% female, mean age 52.6 years (SD 16.5), 18.2% francophone, 57.7% with post-secondary education) completed the survey. 34.0% reported a prior concern about physician's pharmaceutical industry relationships. Acceptability of interactions varied from high for requesting information about a particular drug or small gifts of obvious educational value to the patient, to mixed for free meals to listen to pharmaceutical industry personnel or payment to attend a conference, to low for research recruitment fees, personal use of medication samples or for using information not yet public about a new drug to make investment decisions. Age of the participant influenced ratings of acceptability. There was reasonable agreement (60% participants) with only half of the related reference COI guideline statements. Conclusions Public opinions on physician's pharmaceutical industry interactions differ depending on the scenario but suggest a significant level of concern regarding interactions involving direct financial benefit to physicians.

## Méthodologie – Statistique / Methodology – Statistics

**Blangiardo M., Cameletti M., Baio G., Rue H. (2013). Spatial and spatio-temporal models with R-INLA. *Spatial and Spatio-temporal Epidemiology*, 7 (0) : 39-55.**

**Abstract:** During the last three decades, Bayesian methods have developed greatly in the field of epidemiology. Their main challenge focusses around computation, but the advent of Markov Chain Monte Carlo methods (MCMC) and in particular of the WinBUGS software has opened the doors of Bayesian modelling to the wide research community. However model complexity and database dimension still remain a constraint. Recently the use of Gaussian random fields has become increasingly popular in epidemiology as very often epidemiological data are characterised by a spatial and/or temporal structure which needs to be taken into account in the inferential process. The Integrated Nested Laplace Approximation (INLA) approach has been developed as a computationally efficient alternative to MCMC and the availability of an R package (R-INLA) allows researchers to easily apply this method. In this paper we review the INLA approach and present some applications on spatial and spatio-temporal data.

**Woertman W., Vermeulen B., Groenewoud H., Van der Wilt G.J. (2013). Evidence based policy decisions through a Bayesian approach: The case of a statin appraisal in the Netherlands. *Health policy*, 112 (3) : 234-240.**

**Abstract:** It has often been suggested that Bayesian statistics is more congenial to the informational needs of policy makers than the standard frequentist methods. In order to illustrate this claim, we use both a Bayesian and a frequentist approach for revisiting a recommendation by the Dutch National Health Insurance Board that for all patients requiring lipid reduction, the cheapest alternative (Simvastatin) should be prescribed. We investigate whether Simvastatin and Atorvastatin, the most commonly used alternative, can be considered equivalent in terms of lipid control for patients with heterozygous familial hypercholesterolemia. Priors were elicited from GPs, cardiologists and internists. A systematic review for studies comparing Simvastatin and Atorvastatin was performed. The data from these studies were combined with the priors in a Bayesian meta-analysis. For comparability a frequentist meta-analysis was also performed. The two approaches lead to similar point estimates and

95% intervals. However, the Bayesian outcomes are easier to understand and interpret, and our Bayesian analysis leads to additional outcomes that would have more direct pertinence for policy makers, and which could help them to assess what the data have to say about the questions that are most relevant to the problems they face.

**Allen N., Pichler F., Wang T., Patel S., Salek S. (2013). Development of archetypes for non-ranking classification and comparison of European National Health Technology Assessment systems.** *Health policy*, 113(3):305-12

**Abstract:** INTRODUCTION: European countries are increasingly utilising health technology assessment (HTA) to inform reimbursement decision-making. However, the current European HTA environment is very diverse, and projects are already underway to initiate a more efficient and aligned HTA practice within Europe. This study aims to identify a non-ranking method for classifying the diversity of European HTA agencies process and the organisational architecture of the national regulatory review to reimbursement systems. METHOD/RESULTS: Using a previously developed mapping methodology, this research created process maps to describe national processes for regulatory review to reimbursement for 33 European jurisdictions. These process maps enabled the creation of 2 HTA taxonomic sets. The confluence of the two taxonomic sets was subsequently cross-referenced to identify 10 HTA archetype groups. DISCUSSION: HTA is a young, rapidly evolving field and it can be argued that optimal practices for performing HTA are yet to emerge. Therefore, a non-ranking classification approach could objectively characterise and compare the diversity observed in the current European HTA environment.

**Fischer K.E., Rogowski W.H., Leidl R., Stollenwerk B. (2013). Transparency vs. closed-door policy: Do process characteristics have an impact on the outcomes of coverage decisions? A statistical analysis.** *Health policy*, 112 (3) : 187-196.

**Abstract:** The aim of this study was to analyze influences of process- and technology-related characteristics on the outcomes of coverage decisions. Using survey data on 77 decisions from 13 countries, we examined whether outcomes differ by 14 variables that describe components of decision-making processes and the technology. We analyzed the likelihood of committees covering a technology, i.e. positive (including partial coverage) vs. negative coverage decisions. We performed non-parametric univariate tests and binomial logistic regression with a stepwise variable selection procedure. We identified a negative association between a positive decision and whether the technology is a prescribed medicine ( $p = 0.0097$ ). Other significant influences on a positive decision outcome included one disease area ( $p = 0.0311$ ) and whether a technology was judged to be (cost-) effective ( $p < 0.0001$ ). The first estimation of the logistic regression yielded a quasi-complete separation for technologies that were clearly judged (cost-)effective. In uncertain decisions, a higher number of stakeholders involved in voting (odds ratio = 2.52;  $p = 0.03$ ) increased the likelihood of a positive outcome. The results suggest that decisions followed the lines of evidence-based decision-making. Despite claims for transparent and participative decision-making, the phase of evidence generation seemed most critical as decision-makers usually adopted the assessment recommendations. We identified little impact of process configurations.

## Politique de santé / Health Policy

**McCarthy M., Zeegers P.D. (2013). Public Health Innovation and Research in Europe: introduction to the supplement.** *Eur J Public Health*, 23 Suppl 2 2-5.

**Abstract:** Background: PHIRE (Public Health Innovation and Research in Europe) was developed for the national member associations and individual researchers of the European Public Health Association (EUPHA) to engage collectively with the health research agenda in Europe. It was co-funded by the European Commission's Directorate for Health and Consumers within the EU Health Programme. It was coordinated by EUPHA in a partnership of eight organizations. This article

introduces the Supplement in the European Journal of Public Health presenting the results of PHIRE. Methods: PHIRE used mixed methods to collect data across 30 European countries (European Union 27 plus Iceland, Norway and Switzerland). Seven thematic Sections of EUPHA identified eight cross-national public health innovation projects, and Country Informants to report on national uptake and impact of these innovations. Public health was considered broadly-health determinants and interventions, health services and practice. Through EUPHA's member national public health associations, and by direct country contacts, PHIRE described country public health research strategies and structures, reviewed calls and programmes for research in 1 year and organized stakeholder workshops. PHIRE was reported to the European Commission, and the component reports placed on the EUPHA web page. A draft of the Final Summary Report was sent by email for commentary by selected experts. Results: PHIRE data from the work packages were organized into eight themes for the Supplement. Through the EUPHA thematic Sections, experts described the uptake and impact of eight innovation projects from the EU Health Programme. National reports indicated a positive impact of the innovations in public health 'markets'. Through national public health associations, 75 programmes and calls for public health research were found for 2010, but systems are not comparable and nor is information exchanged or coordinated. Only a few countries have public health research strategies. Having competitive research funding through Ministries of Health is potentially beneficial. There is limited contact between national and European public health research programmes and calls. Experts who were sent the draft PHIRE Summary Report gave generally positive responses on the validity and usefulness of the results. Dissemination has been achieved through meetings during the study and by electronic means thereafter. Conclusion: PHIRE has increased knowledge about public health innovation at national and European levels. Strengthening the public health research system, and demonstrating innovation in public health markets will maximize benefits to Europe's citizens.

**Barnhoorn F., McCarthy M., Deville W., Alexanderson K., Voss M., Conceicao C. (2013). PHIRE (Public Health Innovation and Research in Europe): methods, structures and evaluation. *Eur J Public Health*, 23 Suppl 2 6-11.**

Abstract: Introduction: Public Health Innovation and Research in Europe (PHIRE), building on previous European collaborative projects, was developed to assess national uptake and impacts of European public health innovations, to describe national public health research programmes, strategies and structures and to develop participation of researchers through the organizational structures of the European Public Health Association (EUPHA). This article describes the methods used. METHODS: PHIRE was led by EUPHA with seven partner organisations over 30 months. It was conceived to engage the organisation of EU.

**McCarthy M., Alexanderson K., Voss M., Conceicao C., Grimaud O., Narkauskaite L., Katreniakova Z., Saliba A., Sammut M. (2013). Impact of innovations in national public health markets in Europe. *Eur J Public Health*, 23 Suppl 2 25-29.**

Abstract: BACKGROUND: Social innovations can contribute to health and wellbeing. PHIRE (Public Health Innovation and Research in Europe) investigated the impacts at national level of innovation projects funded by the European Union Public Health Programme. METHODS: Through the European Public Health Association, experts assessed the uptake of the eight public health projects, for 30 European countries. Their reports were assembled by country and, thereafter, national public health associations reviewed the reports. Following stakeholder workshops, or internal and external consultations, 11 national reports were produced which included discussion on the impacts of the public health innovations in national product markets. RESULTS: In 11 countries, there were reports on the eight innovations for 45 (51%) of the possible public health markets. The innovations contributed positively to policy, practice and research, across different levels and in different ways, in 35 (39%) market, while competing innovation activities were recorded in 10 (11%) markets. The workshops also discussed contributing factors and limitations in dissemination and timing for policy cycles. CONCLUSIONS: The impacts of European Union social innovations in public health markets can be identified through national discussions. Further attention should be given to understanding drivers and incentives for successful public health innovations.

**Burkell J.A., Chandler J.A., Shemie S.D. (2013). Attitudes toward Reciprocity Systems for Organ Donation and Allocation for Transplantation. *J Health Polit. Policy Law*, 38 (5) : 957-986.**



**Abstract:** Many of those who support organ donation do not register to become organ donors. The use of reciprocity systems, under which some degree of priority is offered to registered donors who require an organ transplant, is one suggestion for increasing registration rates. This article uses a combination of survey and focus group methodologies to explore the reaction of Canadians to a reciprocity proposal. Our results suggest that the response is mixed. Participants are more convinced of the efficacy than they are of the fairness of a reciprocity system. Those more positive about donation (decided donors and those leaning toward donation) rate the system more positively. Although there is general endorsement of the notion that those who wish to receive should be prepared to give (the Golden Rule), this does not translate into universal support for a reciprocity system. In discussions of efficacy, decided donors focus on the positive impact of reciprocity, whereas undecided donors also reflect on the limits of reciprocity for promoting registration. The results demonstrate divided support for reciprocity systems in the Canadian context, with perceptions of efficacy at the cost of fairness. Further studies are warranted prior to considering a reciprocity system in Canada.

**White J. (2013). Budget-makers and health care systems.** *Health policy*, 112 (3) : 163-171.

**Abstract:** Abstract Health programs are shaped by the decisions made in budget processes, so how budget-makers view health programs is an important part of making health policy. Budgeting in any country involves its own policy community, with key players including budgeting professionals and political authorities. This article reviews the typical pressures on and attitudes of these actors when they address health policy choices. The worldview of budget professionals includes attitudes that are congenial to particular policy perspectives, such as the desire to select packages of programs that maximize population health. The pressures on political authorities, however, are very different: most importantly, public demand for health care services is stronger than for virtually any other government activity. The norms and procedures of budgeting also tend to discourage adoption of some of the more enthusiastically promoted health policy reforms. Therefore talk about rationalizing systems is not matched by action; and action is better explained by the need to minimize blame. The budget-maker's perspective provides insight about key controversies in healthcare policy such as decentralization, competition, health service systems as opposed to health insurance systems, and dedicated vs. general revenue finance. It also explains the frequency of various "gaming" behaviors".

**Morrison C., Dearden A. (2013). Beyond tokenistic participation: Using representational artefacts to enable meaningful public participation in health service design.** *Health policy*, 112 (3) : 179-186.

**Abstract:** Abstract A number of recent policies promote public participation in health service design. Yet, a growing literature has articulated a gap between policy aims and actual practice resulting in public participation becoming tokenistic. Drawing on theory from participatory design, we argue that choosing appropriate artefacts to act as representations can structure discussions between public participants and health professionals in ways that both groups find meaningful and valid. Through a case study of a service improvement project in outpatient services for older people, we describe three representational artefacts: emotion maps, stories, and tracing paper, and explain how they helped to mediate interactions between public participants and health professionals. We suggest that using such representational artefacts can provide an alternative approach to participation that stands in contrast to the current focus on the professionalisation of public participants. We conclude that including participatory designers in projects, to choose or design appropriate representational artefacts, can help to address the policy practice gap of including public participants in health service design.

**Gopalan S.S., Mutasa R., Friedman J., Das A. (2014). Health sector demand-side financial incentives in low- and middle-income countries: A systematic review on demand- and supply-side effects.** *Social Science & Medicine*, 100 (0) : 72-83.

**Abstract:** Abstract Demand-side financial incentive (DSFI) is an emerging strategy to improve health seeking behavior and health status in many low- and middle-income countries. This narrative synthesis assessed the demand- and supply-side effects of DSFI. Forty one electronic data bases were searched to screen relevant experimental and quasi-experimental study designs. Out of the 64 selected papers, 28 were eligible for this review and they described 19 DSFI initiatives across Asia, Africa and Latin America. There were three categories of initiatives, namely long-run multi-sectoral programs or LMPs (governmental); long-run health-exclusive programs (governmental); and short-run

health-exclusive initiatives (both governmental and non-governmental). Irrespective of the nature of incentives and initiatives, all DSF programs could achieve their expected behavioral outcomes on healthcare seeking and utilization substantially. However, there existed a few negative and perverse outcomes on health seeking behavior and DSF's impact on continuous health seeking choices (e.g. bed net use and routine adult health check-ups) was mixed. Their effects on maternal health status, diarrhea, malaria and out-of-pocket expenditure were under-explored; while chronic non-communicable diseases were not directly covered by any DSF programs. DSF could reduce HIV prevalence and child deaths, and enhance nutritional and growth status of children. The direction and magnitude of their effects on health status was elastic to the evaluation design employed. On health system benefits, despite prioritizing on vulnerable groups, DSF's substantial effect on the poorest of the poor was mixed compared to that on the relatively richer groups. Though DSF initiatives intended to improve service delivery status, many could not optimally do so, especially to meet the additionally generated demand for care. Causal pathways of DSF's effects should be explored in-depth for mid-course corrections and cross-country learning on their design, implementation and evaluation. More policy-specific analyses on LMPs are needed to assess how multi-sectoral approaches can be cost-effective and sustainable in the long run compared to health exclusive incentives.

## Prévention / Prevention

**Carrieri V., Wuebker A. (2013). Assessing inequalities in preventive care use in Europe. *Health Policy*, 113 (3) : pp. 247-257.**

**Abstract:** This paper presents new international evidence on the extent of inequalities in breast cancer screening and blood test (cholesterol and blood sugar test) in 13 European Countries using data from the 2009 wave of the Survey of Health, Ageing and Retirement in Europe (SHARE). One important contribution of the paper is the inclusion of preexisting health conditions in the needs standardization procedure with the aim of taking into account utilization due to diagnosis or follow-up reasons. We find evidence of pro-rich inequalities in blood test use in some countries while high inequalities emerge in virtually every country with respect to mammography use. Decomposition analysis reveals that inequalities in mammography use are mostly driven by income while preventive needs distribution is only slightly pro-rich. On the other side, richer individuals appear to be much more likely to do blood tests despite their substantially lower diagnostic needs for that care. Generally, inequalities in mammography use are higher in countries without national breast cancer screening programs or in countries with only regional or less participated programs. Inequalities in blood tests are higher in countries with a high share of out-of-pocket payments and/or non universalistic entitlement to insurance coverage.

## Prévision – Evaluation / Prevision – Evaluation

**Sandmann F.G., Franken M.G., Steenhoek A., Koopmanschap M.A. (2013). Do reassessments reduce the uncertainty of decision making? Reviewing reimbursement reports and economic evaluations of three expensive drugs over time. *Health policy*, 112 (3) : 285-296.**

**Abstract:** OBJECTIVE: To investigate the desirability and feasibility of a cyclic reimbursement process to address uncertainty accompanying initial decision making. METHODS: We performed desk research for three expensive outpatient drugs: imatinib, pegfilgrastim, and adalimumab. We analysed the evidence base at the time of decision making (T=0) and May 2011 (T=1). For T=0, public reports of the Dutch reimbursement agency were investigated regarding available clinical and economic evidence, and a systematic review was performed to retrieve additional economic evidence. For T=1, the systematic review was extended till May 2011. RESULTS: The evidence base at T=0 lacked

information on clinically relevant outcomes such as mortality, morbidity, and quality of life (5/8 reports), (long-term) adverse events (2/8 reports) and experience in use (1/8 reports). One budget impact analysis and one economic evaluation were available but no pharmacoeconomic dossiers. The systematic review identified 39 cost-utility studies (of 52 economic evaluations) for T=1, characterised by methodological heterogeneity. **CONCLUSIONS:** Given the considerable uncertainty accompanying initial decision-making, a more cyclic reimbursement process seems feasible to reduce uncertainty regarding the therapeutical and economical value of expensive drugs. A mandatory evidence development requirement seems desirable to sufficiently meet decision makers' needs.

**Klingler C., Shah S.M., Barron A.J., Wright J.S. (2013). Factors that led to the implementation of the efficiency frontier approach to health economic evaluation in Germany: Let's talk more about the elephant.** *Health policy*, 112 (3) : 299-300.

**Sandmann F., Gerber-Grote A., Lhachimi S. (2013). Factors that led to the implementation of the efficiency frontier approach in health economic evaluation in Germany: Do not avoid the elephant in the room. Comment on Klingler et al.** *Health Policy* 109 (2013) 270-280). *Health policy*, 112 (3) : 297-298.  
PM:24120262

**Bracco A., Krol M. (2013). Economic evaluations in European reimbursement submission guidelines: current status and comparisons.** *Expert Review of Pharmacoeconomics & Outcomes Research*, 13 (5) : 579-595.

## Psychiatrie / Psychiatry

**Allermoz E. (2013). Des téléconsultations en psychiatrie (Seine-Maritime).** *Médecins : Bulletin d'Information de l'Ordre National des Médecins*, (31) :

Abstract: La Seine-Maritime compte deux fois moins de psychiatres que la moyenne nationale. Un dispositif de téléconsultation en psychiatrie gériatrique, coordonné par le centre hospitalier du Rouvray, tente de pallier ce déficit. Ce genre d'initiative est encore rare en France.  
[http://www.conseil-national.medecin.fr/sites/default/files/cn\\_bulletin/medecins31\\_1.pdf](http://www.conseil-national.medecin.fr/sites/default/files/cn_bulletin/medecins31_1.pdf)

## Sociologie – Anthropologie / Sociology – Anthropology

**Mauss M. (2012). Essai sur le don : forme et raison de l'échange dans les sociétés archaïques.** Quadrige. Paris : Presses Universitaires de France

Abstract: Pourquoi lire encore de nos jours cet essai, que Mauss lui-même reconnaissait comme imparfait, et surtout comment le comprendre ? Dans une introduction essentielle, Florence Weber analyse le travail de Mauss, la synthèse des travaux ethnographiques antérieurs, les réinterprétations théoriques qui en ont été faites, les multiples recherches empiriques qui s'en sont inspirées. « Le lire aujourd'hui, c'est prendre la mesure des perspectives qu'il a ouvertes et retrouver à leur racine les principes de l'approche ethnographique des prestations sans marché, un continent mieux exploré aujourd'hui. C'est aussi [...] apprendre à en finir avec le don. » (4e de couverture).

**Healy K. (2006). Last best gifts : altruism and the market for human blood and organs :** Chicago : University of Chicago

Abstract: More than any other altruistic gesture, blood and organ donation exemplifies the true spirit of self-sacrifice. Donors literally give of themselves for no reward so that the life of an individual—often

anonymous—may be spared. But as the demand for blood and organs has grown, the value of a system that depends solely on gifts has been called into question, and the possibility has surfaced that donors might be supplemented or replaced by paid suppliers. *Last Best Gifts* offers a fresh perspective on this ethical dilemma by examining the social organization of blood and organ donation in Europe and the United States. Gifts of blood and organs are not given everywhere in the same way or to the same extent—contrasts that allow Kieran Healy to uncover the pivotal role that institutions play in fashioning the contexts for donations. Procurement organizations, he shows, sustain altruism by providing opportunities to give and by producing public accounts of what giving means. In the end, Healy suggests, successful systems rest on the fairness of the exchange, rather than the purity of a donor's altruism or the size of a financial incentive (4e de couverture).

**Hollue C. (2013). Laïcité : comment concilier pratique médicale et religion ?** (Dossier). *Médecins : Bulletin d'Information de l'Ordre National des Médecins*, (31) :

Abstract: En médecine de ville comme à l'hôpital, les praticiens sont régulièrement confrontés à des situations incompatibles avec le respect du principe de laïcité. Ils peuvent se trouver démunis, malgré l'existence de règles, qu'il convient de rappeler. Cet article tente une analyse de la question.

[http://www.conseil-national.medecin.fr/sites/default/files/cn\\_bulletin/medecins31\\_1.pdf](http://www.conseil-national.medecin.fr/sites/default/files/cn_bulletin/medecins31_1.pdf)

## Soins de santé primaires / Primary Health Care

**Mc Millan S., Kendall E., Sav A., King M.A., Whitty J.A., Kelly F., Wheeler A.J. (2013). Patient-Centered Approaches to Health Care.** *Medical Care Research and Review*, 70 (6) : 567-596.

Abstract: There is growing interest in patient-centered care, but there is little guidance about the interventions required for its delivery and whether it leads to better health outcomes. This systematic review evaluates the efficacy of patient-centered care interventions for people with chronic conditions. Thirty randomized controlled trials were identified from health-related databases. The findings indicated that most interventions were based on the notion of empowering care and included attempts to educate consumers or prompt them about how to manage a health consultation. Other common interventions focused on training providers in delivering empowering care. Although it was difficult to draw firm conclusions because of the moderate to high risk of bias of the research designs, this review has shown some promising findings from implementing a patient-centered care approach. There appeared to be benefits associated with this model of care in terms of patient satisfaction and perceived quality of care.

**Kimberley G., Mark F., Gillian S., Eric S. (2013). Motivators and Barriers to Using Patient Experience Reports for Performance Improvement.** *Medical Care Research and Review*, 70 (6) : 621-635.

Abstract: Increasingly, patient experience surveys are available to provide performance feedback to physician groups. However, limited published literature addresses factors influencing use of these reports for performance improvement. To address this gap, we conducted semistructured interviews with leaders of Massachusetts physician groups. We asked about factors influencing groups' use of performance data and report characteristics. Motivating characteristics included having group leaders who emphasized a positive patient experience and prioritized patient retention; public reporting was not an important motivator for most groups. Full physician panels were perceived as a barrier to use of reports. Performance reports from a statewide public reporting collaborative were not sufficient for the majority of groups, with many seeking external reports. As policy makers create financial incentives to support performance improvement, assisting leaders to articulate the professional case for patient experience and enhancing the content and timing of performance reports may be important.

**Al-Ani S., Spigt M., Hofset P., Melbye H. (2013). Predictors of exacerbations of asthma and COPD during one year in primary care. *Family Practice*, 30 (6) : 621-628.**

**Abstract:** Aims. To investigate the incidence of asthma and chronic obstructive pulmonary disease (COPD) exacerbations in primary care during one year and to identify risk factors for such events. Methods. The study was carried out at seven general practice offices in Norway. Patients aged 40 years or more registered with a diagnosis of asthma and/or COPD the previous 5 years were included. After a baseline examination, the participants consulted their GP during exacerbations for the following 12 months. A questionnaire on exacerbations during the follow-up year was distributed to all. Univariable and multivariable logistic regression was performed to determine predictors of future exacerbations. Results. Three hundred and eighty patients attended the baseline examination and complete follow-up data were retrieved from 340 patients. COPD as defined by forced expiratory volume in the first second of expiration/forced vital capacity (FEV1/FVC) < 0.7, was found in 132 (38.8%) patients. One hundred and fifty-nine patients (46.8%) experienced one exacerbation or more and 101 (29.7%) two exacerbations or more. Patients who had an exacerbation treated with antibiotics or systemic corticosteroids or leading to hospitalization the year before baseline (N = 88) had the highest risk of getting an exacerbation during the subsequent year (odds ratio 9.2), whether the FEV1/FVC was below 0.7 or not. Increased risk of future exacerbations was also related to age  $\geq$  65 years and limitations in social activities, but not to the FEV1. Conclusions. The study confirms that previous exacerbations strongly predict future exacerbations in patients with COPD or asthma. Identification and a closer follow-up of patients at risk of such events could promote earlier treatment when necessary and prevent a rapid deterioration of their condition.

**Weiss M.C., Platt J., Riley R., Taylor G., Horrocks S., Taylor A. (2013). Solicitations in GP, nurse and pharmacist prescriber consultations: an observational study. *Family Practice*, 30 (6) : 712-718.**

**Abstract:** Background. The opening solicitation is a key element of the primary care consultation as it enables patients to express their ideas, concerns and expectations that can lead to improved patient outcomes. However, in practice, this may not always occur. With nurses and pharmacists now able to prescribe, this research explored the opening solicitation in a multi-professional context. Objective. To compare the nature, frequency and response to opening solicitations used in consultations with nurse prescribers (NPs), pharmacist prescribers (PPs) and GPs. Methods. An observational study using audio-recordings of NP, PP and GP patient consultations in 36 primary care practices in southern England. Between 713 prescriber patient consultations were recorded per prescriber. A standardized pro forma based upon previous research was used to assess recordings. Results. Five hundred and thirty-three patient consultations (213 GPs, 209 NPs, 111 PPs) were audio-recorded with 51 prescribers. Across the prescribing groups, pharmacists asked fewer opening solicitations, while GPs used more open questions than NPs and PPs. The mean number of patient agenda items was 1.3 with more items in GP consultations. Patients completed their opening agenda in 20% of consultations, which was unaffected by professional seen. Redirection of the patient's agenda occurred at 24 seconds (mean). Conclusion. All prescribers should be encouraged to use more open questions and ask multiple solicitations throughout the consultation. This is likely to result in greater expression of patients' concerns and improved patient outcomes.

**Bodenheimer T.S., Smith M.D. (2013). Primary care: proposed solutions to the physician shortage without training more physicians. *Health Aff.(Millwood.)*, 32 (11) : 1881-1886.**

**Abstract:** The adult primary care "physician shortage" is more accurately portrayed as a gap between the adult population's demand for primary care services and the capacity of primary care, as currently delivered, to meet that demand. Given current trends, producing more adult primary care clinicians will not close the demand-capacity gap. However, primary care capacity can be greatly increased without many more clinicians: by empowering licensed personnel, including registered nurses and pharmacists, to provide more care; by creating standing orders for nonlicensed health personnel, such as medical assistants, to function as panel managers and health coaches to address many preventive and chronic care needs; by increasing the potential for more patient self-care; and by harnessing technology to add capacity.

**Dower C., Moore J., Langelier M. (2013). It is time to restructure health professions scope-of-practice regulations to remove barriers to care.** *Health Aff.(Millwood.)*, 32 (11) : 1971-1976.

Abstract: Regulation and licensure of health professionals-nurses, physicians, pharmacists, and others-currently falls to the states. State laws and regulations define legal scopes of practice for these practitioners. Concern is growing that this system cannot support workforce innovations needed for an evolving health care system or for successful implementation of the Affordable Care Act. Existing state-based laws and regulations limit the effective and efficient use of the health workforce by creating mismatches between professional competence and legal scope-of-practice laws and by perpetuating a lack of uniformity in these laws and regulations across states. State laws limit needed overlap in scopes of practice among professions that often share some tasks and responsibilities, and the process for changing the laws is slow and adversarial. We highlight reforms needed to strengthen health professions regulation, including aligning scopes of practice with professional competence for each profession in all states; assuring the regulatory flexibility needed to recognize emerging and overlapping roles for health professionals; increasing the input of consumers; basing decisions on the best available evidence and allowing demonstration programs; and establishing a national clearinghouse for scope-of-practice information.

**Shipman S.A., Sinsky C.A. (2013). Expanding primary care capacity by reducing waste and improving the efficiency of care.** *Health Aff.(Millwood.)*, 32 (11) : 1990-1997.

Abstract: Most solutions proposed for the looming shortage of primary care physicians entail strategies that fall into one of three categories: train more, lose fewer, or find someone else. A fourth strategy deserves more attention: waste less. This article examines the remarkable inefficiency and waste in primary care today and highlights practices that have addressed these problems. For example, delegating certain administrative tasks such as managing task lists in the electronic health record can give physicians more time to see additional patients. Flow managers who guide physicians from task to task throughout the clinical day have been shown to improve physicians' efficiency and capacity. Even something as simple as placing a printer in every exam room can save each physician twenty minutes per day. Modest but system-wide improvements could yield dramatic gains in physician capacity while potentially reducing physician burnout and its implications for the quality of care. If widely adopted, small efforts to empower non physicians, reengineer workflows, exploit technology, and update policies to eliminate wasted effort could yield the capacity for millions of additional patient visits per year in the United States.

**Weiner J.P., Yeh S., Blumenthal D. (2013). The Impact Of Health Information Technology And e-Health On The Future Demand For Physician Services.** *Health Aff.(Millwood.)*, 32 (11) : 1998-2004.

Abstract: Arguably, few factors will change the future face of the American health care workforce as widely and dramatically as health information technology (IT) and electronic health (e-health) applications. We explore how such applications designed for providers and patients will affect the future demand for physicians. We performed what we believe to be the most comprehensive review of the literature to date, including previously published systematic reviews and relevant individual studies. We estimate that if health IT were fully implemented in 30 percent of community-based physicians' offices, the demand for physicians would be reduced by about 4-9 percent. Delegation of care to nurse practitioners and physician assistants supported by health IT could reduce the future demand for physicians by 4-7 percent. Similarly, IT-supported delegation from specialist physicians to generalists could reduce the demand for specialists by 2-5 percent. The use of health IT could also help address regional shortages of physicians by potentially enabling 12 percent of care to be delivered remotely or asynchronously. These estimated impacts could more than double if comprehensive health IT systems were adopted by 70 percent of US ambulatory care delivery settings. Future predictions of physician supply adequacy should take these likely changes into account.

**Kantarevic J., Kralj B. (2013). Link between pay for performance incentives and physician payment mechanisms: evidence from the diabetes management incentive in Ontario.** *Health Econ*, 22 (12) : 1417-1439.

**Abstract:** Pay for performance (P4P) incentives for physicians are generally designed as additional payments that can be paired with any existing payment mechanism such as a salary, fee-for-services and capitation. However, the link between the physician response to performance incentives and the existing payment mechanisms is still not well understood. In this article, we study this link using the recent primary care physician payment reform in Ontario as a natural experiment and the Diabetes Management Incentive as a case study. Using a comprehensive administrative data strategy and a difference-in-differences matching strategy, we find that physicians in a blended capitation model are more responsive to the Diabetes Management Incentive than physicians in an enhanced fee-for-service model. We show that this result implies that the optimal size of P4P incentives vary negatively with the degree of supply-side cost-sharing. These results have important implications for the design of P4P programs and the cost of their implementation.

**Solomon J., Knapp P., Raynor D.K., Atkin K. (2013). Worlds apart? An exploration of prescribing and medicine-taking decisions by patients, GPs and local policy makers. *Health policy*, 112 (3) : 264-272.**

**Abstract:** Current healthcare policy in the UK has been shaped by two major forces; increasing accountability to evidence-based standards and increasing patient involvement. Shared decision-making brings the patient into prescribing decisions, and guidelines introduce a third decision-maker, the policy maker, into the doctor-patient consultation. This study explored the decision-making processes used by patients and GPs in comparison to local policy makers. **METHOD:** Qualitative interviews with 8GPs, 14 patients and 2 PCT Prescribing Advisers, followed by quantitative questionnaires completed by 305GPs and 533 patients. **RESULTS:** Patients made individual medicine-taking decisions based on experience, personal financial and human cost, trust and the relational aspects of their interactions with doctors over time. In contrast local implementation of prescribing guidelines was based on consideration of financial costs, efficacy and risks, based on objective clinical evidence at a population level. GPs adopted a mid-position between these two polar views. Guidelines are written from a different perspective to the worldview of patients, and they tend to downplay the criteria most important to patients. This has the potential to have a harmful effect on patients' medicine-taking and adherence. Paradoxically, enforcing the use of guidelines could inhibit the achievement of guideline targets.

**Groenewegen P.P., Dourgnon P., Gress S., Jurgutis A., Willems S. (2013). Strengthening weak primary care systems: Steps towards stronger primary care in selected Western and Eastern European countries. *Health policy*, 113 (1-2) : 170-179.**

**Abstract:** European health care systems are facing diverse challenges. In health policy, strong primary care is seen as key to deal with these challenges. European countries differ in how strong their primary care systems are. Two groups of traditionally weak primary care systems are distinguished. First a number of social health insurance systems in Western Europe. In these systems we identified policies to strengthen primary care by small steps, characterized by weak incentives and a voluntary basis for primary care providers and patients. Secondly, transitional countries in Central and Eastern Europe (CEE) that transformed their state-run, polyclinic based systems to general practice based systems to a varying extent. In this policy review article we describe the policies to strengthen primary care. For Western Europe, Germany, Belgium and France are described. The CEE transformed their systems in a completely different context and urgency of problems. For this group, we describe the situation in Estonia and Lithuania, as former states of the Soviet Union that are now members of the EU, and Belarus which is not. We discuss the usefulness of voluntary approaches in the context of acceptability of such policies and in the context of (absence of) European policies.

**Damiani G., Silvestrini G., Federico B., Cosentino M., Marvulli M., Tirabassi F., Ricciardi W. (2013). A systematic review on the effectiveness of group versus single-handed practice. *Health policy*, 113 (1-2) : 180-187.**

**Abstract:** **BACKGROUND:** Since the 1970s, many countries have employed the use of the General practitioner group practice, but there is contrasting evidence about its effectiveness. A systematic review was performed to assess whether group practice has a more positive impact compared with the single-handed practice on different aspects of health care. **METHODS:** A systematic review was conducted by querying electronic databases and reviewing articles published between 1990 and 2012.

A quality assessment was performed. The effect of group practice was evaluated by collecting all items analysed by the articles into four main categories: (1) studies of quality (measured in terms of clinical processes) and productivity (measured in terms of throughput), named "Clinical process measures and throughput"; (2) studies exploring physician's opinion - "Doctor's perspective"; (3) studies looking into the use of innovation, information and communication technology (ICT) and quality assurance - "Innovation, ICT and quality assurance"; (4) studies focused on patient's opinion - "Patient's perspective". The results were synthesized according to three levels of scientific evidence. RESULTS: A total of 26 studies were selected. The most studied category was Clinical process measures and throughput (58%). A positive impact of group medicine on "Clinical process measures and throughput", "Doctor's perspective", "Innovation, ICT and quality assurance" was found. There was contrasting evidence considering the "Patient's perspective". CONCLUSIONS: Group practice might be a successful organizational requirement to improve the quality of clinical practice in Primary Health Care. Further comparative studies are needed to investigate the impact of organizational and professional determinants such as physician's economic incentives, mode of payment, size of the groups and multispecialty on the effectiveness of medical primary care.

**Visca M., Donatini A., Gini R., Federico B., Damiani G., Francesconi P., Grilli L., Rampichini C., Lapini G., Zocchetti C., Di S.F., Brambilla A., Moirano F., Bellentani D. (2013). Group versus single handed primary care: A performance evaluation of the care delivered to chronic patients by Italian GPs. *Health policy*, 113 (1-2) : 188-198.**

Abstract: OBJECTIVES: In family medicine contrasting evidence exists on the effectiveness of team practice compared with solo practice on chronic disease management. In Italy, several experiences of team practice have been introduced since the late 1990s but few studies detail their impact on the quality of care. The aim of this paper is to evaluate the impact of team practice in family medicine in six Italian regions using chronic disease management process indicators as a measure of outcome. METHODS: Cross-sectional studies were performed to assess impact on quality of care for diabetes, congestive heart failure and ischaemic heart disease. The impact of team vs. solo practice was approximated through performance comparison of general practitioners (GPs) adhering to a team with respect to GPs working in a solo practice. Among the 2082 practitioners working in the 6 regions those assisting 300+ patients were selected. Quality of care towards 164,267 patients having at least one of three chronic conditions was estimated for the year 2008 using administrative databases. Quality indicators (% of patients receiving appropriate care) were selected (4 for diabetes, 4 for congestive heart failure, 3 for ischaemic heart disease) and a total score was computed for each patient. For each disease the response variable associated to each physician was the average score of the patients on his/her list. A multilevel model was estimated assessing the impact of team vs. solo practice. RESULTS: No impact was found for diabetes and heart failure. For ischaemic heart disease a slightly significant impact was observed (0.040; 95% CI: 0.015, 0.065). CONCLUSIONS: No significant difference was found between team practice and solo practice on chronic disease management in six Italian regions.

**Weeks W.B., Paraponaris A., Ventelou B. (2013). Sex-based differences in income and response to proposed financial incentives among general practitioners in France. *Health policy*, 113 (1-2) : 199-205.**

Abstract: Women represent a growing proportion of the physician workforce, worldwide. Therefore, for the purposes of workforce planning, it is increasingly important to understand differences in how male and female physicians work and might respond to financial incentives. A recent survey allowed us to determine whether sex-based differences in either physician income or responses to a hypothetical increase in reimbursement exist among French General Practitioners (GPs). Our analysis of 828 male and 244 female GPs' responses showed that females earned 35% less per year from medical practice than their male counterparts. After adjusting for the fact that female GPs had practiced medicine fewer years, worked 11% fewer hours per year, and spent more time with each consultation, female GPs earned 11,194euro, or 20.6%, less per year (95% CI: 7085euro-15,302euro less per year). Male GPs were more likely than female GPs to indicate that they would work fewer hours if consultation fees were to be increased. Our findings suggest that, as the feminization of medicine increases, the need to address gender-based income disparities increases and the tools that French policymakers use to regulate the physician supply might need to change.



**Kristensen T., Rose O.K., Sortso C., Ejersted C., Thomsen J.L., Halling A. (2013). Resources allocation and health care needs in diabetes care in Danish GP clinics. *Health policy*, 113 (1-2) : 206-215.**

**Abstract:** BACKGROUND: In several countries, morbidity burdens have prompted authorities to change the system for allocating resources among patients from a demographic-based to a morbidity-based casemix system. In Danish general practice clinics, there is no morbidity-based casemix adjustment system. AIM: The aim of this paper was to assess what proportions of the variation in fee-for-service (FFS) expenditures are explained by type 2 diabetes mellitus (T2DM) patients' co-morbidity burden and illness characteristics. METHODS AND DATA: We use patient morbidity characteristics such as diagnostic markers and co-morbidity casemix adjustments based on resource utilisation bands and FFS expenditures for a sample of 6706 T2DM patients in 59 general practices for the year 2010. We applied a fixed-effect approach. RESULTS: Average annual FFS expenditures were approximately 398 euro per T2DM patient. Expenditures increased progressively with the patients' degree of co-morbidity and were higher for patients who suffered from diagnostic markers. A total of 17-25% of the expenditure variation was explained by age, gender and patients' morbidity patterns. CONCLUSION: T2DM patient morbidity characteristics are significant patient related FFS expenditure drivers in diabetes care. To address the specific health care needs of T2DM patients in GP clinics,

**Tsiachristas A., Dijkers C., Boland M.R., Rutten-van Molken M.P. (2013). Exploring payment schemes used to promote integrated chronic care in Europe. *Health policy*, 113(3):296-304**

**Abstract:** The rising burden of chronic conditions has led several European countries to reform healthcare payment schemes. This paper aimed to explore the adoption and success of payment schemes that promote integration of chronic care in European countries. A literature review was used to identify European countries that employed pay-for-coordination (PFC), pay-for-performance (PFP), and bundled payment schemes. Existing evidence from the literature was supplemented with fifteen interviews with chronic care experts in these countries to obtain detailed information regarding the payment schemes, facilitators and barriers to their implementation, and their perceived success. Austria, France, England, the Netherlands, and Germany have implemented payment schemes that were specifically designed to promote the integration of chronic care. Prominent factors facilitating implementation included stakeholder cooperation, adequate financial incentives for stakeholders, and flexible task allocation among different care provider disciplines. Common barriers to implementation included misaligned incentives across stakeholders and gaming. The implemented payment schemes targeted different stakeholders (e.g. individual caregivers, multidisciplinary organizations of caregivers, regions, insurers) in different countries depending on the structure and financing of each health care system. All payment reforms appeared to have changed the structure of chronic care delivery. PFC, as it was implemented in Austria, France and Germany, was perceived to be the most successful in increasing collaboration within and across healthcare sectors, whereas PFP, as it was implemented in England and France, was perceived most successful in improving other indicators of the quality of the care process. Interviewees stated that the impact of the payment reforms on healthcare expenditures remained questionable. The success of a payment scheme depends on the details of the specific implementation in a particular country, but a combination of the schemes may overcome the barriers of each individual scheme.

**Haji Ali A.H., Gray J., Beilby J., Holton C., Karnon J. (2013). A Model-Based Economic Evaluation of Improved Primary Care Management of Patients with Type 2 Diabetes in Australia. *Appl. Health Econ Health Policy*, 11 (6) : 661-670.**

**Abstract:** BACKGROUND: There are few studies investigating the economic value of the Australian practice nurse workforce on the management of chronic conditions. This is particularly important in Australia, where the government needs evidence to inform decisions on whether to maintain or redirect current financial incentives that encourage practices to recruit practice nurses. OBJECTIVE: The objective of this study was to estimate the lifetime costs and quality-adjusted life-years (QALYs) associated with two models of practice nurse involvement in clinical-based activities (high and low level) in the management of type 2 diabetes within the primary care setting. METHODS: A previously validated state transition model (the United Kingdom Prospective Diabetes Study Outcomes Model) was adapted, which uses baseline prognostic factors (e.g. gender, haemoglobin A1c [HbA1c]) to

predict the risk of occurrence of diabetes-related complications (e.g. stroke). The model was populated by data from Australian and UK observational studies. Costs and utility values associated with complications were summed over patients' lifetimes to estimate costs and QALY gains from the perspective of the health care system. All costs were expressed in 2011 Australian dollars (AU\$). The base-case analysis assumed a 40-year time horizon with an annual discount rate of 5 %. RESULTS: Relative to low-level involvement of practice nurses in the provision of clinical-based activities, the high-level model was associated with lower mean lifetime costs of management of complications (-AU\$8,738; 95 % confidence interval [CI] -AU\$12,522 to -AU\$4,954), and a greater average gain in QALYs (0.3; 95 % CI 0.2-0.4). A range of sensitivity analyses were performed, in which the high-level model was dominant in all cases. CONCLUSION: Our results suggest that the high-level model is a dominant management strategy over the low-level model in all modelled scenarios. These findings indicate the need for effective primary care-based incentives to encourage general practices not only to employ practice nurses, but to better integrate them into the provision of clinical services.

## Systèmes de santé / Health Systems

**Januleviciute J., Askildsen J.E., Kaarboe O., Holmas T.H., Sutton M. (2013). The impact of different prioritisation policies on waiting times: Case studies of Norway and Scotland.** *Social Science & Medicine*, 97 (0) : 1-6.

Abstract: We investigate the distributional consequences of two different waiting times initiatives, one in Norway, and one in Scotland. The primary focus of Scotland's recent waiting time reforms, introduced in 2003, and modified in 2005 and 2007, has been on reducing maximum waiting times through the imposition of high profile national targets accompanied by increases in resources. In Norway, the focus of the reform introduced in September 2004, has been on assigning patients referred to hospital a maximum waiting time based on disease severity, the expected benefit and the cost-effectiveness of the treatment. We use large, national administrative datasets from before and after each of these reforms and assign priority groups based on the maximum waiting times stipulated in medical guidelines. The analysis shows that the lowest priority patients benefited most from both reforms. This was at the cost of longer waiting times for patients that should have been given higher priority in Norway, while Scotland's high priority patients remained unaffected.

**Chen W.Y. (2013). Does healthcare financing converge? Evidence from eight OECD countries.** *Int J Health Care Finance Econ*, 13 (3-4) : 279-300.

Abstract: This study investigated the convergence of healthcare financing across eight OECD countries during 1960-2009 for the first time. The panel stationary test incorporating both shapes of multiple structural breaks (i.e., sharp drifts and smooth transition shifts) and cross-sectional dependence was used to provide reliable evidence of convergence in healthcare financing. Our results suggested that the public share of total healthcare financing in eight OECD countries has exhibited signs of convergence towards that of the US. The convergence of healthcare financing not only reflected a decline in the share of public healthcare financing in these eight OECD countries but also exhibited an upward trend in the share of public healthcare financing in the US over the period of 1960-2009.

**Kakinaka M., Kato R.R. (2013). Regulated medical fee schedule of the Japanese health care system.** *Int J Health Care Finance Econ*, 13 (3-4) : 301-317.

Abstract: This study presents a theoretical framework for examining the effect of the Japanese government-regulated medical price schedule, 'Shinryo-Houshu-Seido,' on the behavior of medical providers. In particular, we discuss the optimal rule of this price schedule for the regulator, taking into account information asymmetry between the regulator and providers. Our simple model predicts that heterogeneous providers either under-provide or over-provide medical inputs in comparison with the socially optimal outcome. Moreover, our results show that when the allocated budget is reduced to a certain level, even the second-best outcome becomes unachievable, no matter how the price schedule

is regulated. While the limited budget size is shown to have a clear negative effect on social welfare, we suggest that the prospect of obtaining the second-best outcome is left to negotiation between the regulator and the budget allocator.

**Ifanti A.A., Argyriou A.A., Kalofonou F.H., Kalofonos H.P. (2013). Financial crisis and austerity measures in Greece: Their impact on health promotion policies and public health care.** *Health policy*, 113 (1-2) : 8-12.

Abstract: This review study explores the available data relating to the impact of financial crisis and subsequently applied austerity measures on the health care, social services and health promotion policies in Greece. It is evident that Greece is affected more than any other European country by the financial crisis. Unemployment, job insecurity, income reduction, poverty and increase of mental disorders are among the most serious consequences of crisis in the socioeconomic life. The health system is particularly affected by the severe austerity measures. The drastic curtailing of government spending has significantly affected the structure and functioning of public hospitals that cope with understaffing, deficits, drug shortage and basic medical supplies. Moreover, health promotion policies are constrained, inhibiting thus the relevant initiatives toward disease prevention and health promotion education practices. Overall, the current economic situation in Greece and its impact on real life and health care is quite concerning. Policy makers should not disregard the implications that austerity and fiscal policies have on the health sector. Greater attention is needed in order to ensure that individuals would continue getting public health care and having access to preventive and social support services. To face the economic hardship, policy makers are expected to implement human-centered approaches, safeguarding the human dignity and the moral values.

**Briggs A.D. (2013). How changes to Irish healthcare financing are affecting universal health coverage.** *Health policy*, 113 (1-2) : 45-49.

Abstract: In 2010, the World Health Organisation (WHO) published the World Health Report - Health systems financing: the path to universal coverage. The Director-General of the WHO, Dr Margaret Chan, commissioned the report "in response to a need, expressed by rich and poor countries alike, for practical guidance on ways to finance health care". Given the current context of global economic hardship and difficult budgetary decisions, the report offered timely recommendations for achieving universal health coverage (UHC). This article analyses the current methods of healthcare financing in Ireland and their implications for UHC. Three questions are asked of the Irish healthcare system: firstly, how is the health system financed; secondly, how can the health system protect people from the financial consequences of ill-health and paying for health services; and finally, how can the health system encourage the optimum use of available resources? By answering these three questions, this article argues that the Irish healthcare system is not achieving UHC, and that it is unclear whether recent changes to financing are moving Ireland closer or further away from the WHO's ambition for healthcare for all.

**Gallo P., Gene-Badia J. (2013). Cuts drive health system reforms in Spain.** *Health Policy*, 113 (1-2) : 1-7.

Abstract: The economic crisis is largely shaping health policy in Spain. This paper reports on major changes in the health care system, both nationally and regionally, as a consequence of sizable cutbacks and new pieces of legislation. The most relevant changes to the system introduced during the last year are having an impact on who is insured, which benefits are covered, and what share of the cost of service provision is contributed by the population, while at the same time reducing salaries and working conditions in the sector. We further report on the consequences these changes are having, and the roles played by key actors and organisations in the system.

**Richardson L., Konisky D.M. (2013). Personal and Collective Evaluations of the 2010 Health Care.** *J Health Polit. Policy Law*, 38 (5) : 921-956.

Abstract: The 2010 health care reform law has been as controversial as any piece of American legislation in recent memory. Although numerous polls have been conducted on the public's views of the reform, we do not know much about how citizens evaluated the policy alternatives. Are citizens

more focused on how policy affects them personally or how it affects the nation as a whole? Further, are these evaluations made more on the basis of past experience or assessments of how the policy will affect the future? Using an original survey of public opinion administered during the 2009 congressional debate, we examine how these evaluative dimensions (and several other factors) shaped public support for overall reform, for associated policy goals, and for available policy tools. We find evidence that retrospective and prospective collective evaluations mattered most, as did personal prospective assessments, but evidence on personal retrospective factors is somewhat mixed.

**Powell M., Miller R. (2013). Privatizing the English National Health Service: An Irregular Verb? *J Health Polit. Policy Law*, 38 (5) : 1051-1059.**

Abstract: This article explores different stakeholder perspectives of "privatization" in the English National Health Service (NHS). Much of the academic literature makes empirical claims about privatization on the basis of absent or shaky definitions of the term, resulting in much of the debate on this issue largely being a "non-debate," where opponents talk past rather than to each other. We aim to throw light on privatization by applying the lens of the "three-dimensional" approach (ownership, finance, and regulation) of the mixed economy of welfare to the views of key voices within these debates. These stakeholder perspectives are political (parliamentary debates), public (opinion polls), clinical provider (British Medical Association and Royal College of Nursing), and campaigning groups. We argue that in terms of grammar, "privatize" seems to be an irregular verb: I want more private-sector involvement; you wish to privatize the NHS. The term privatization is multidimensional, and definitions and operationalizations of the term are often implicit, unclear, and conflicting, resulting in differing accounts of the occurrence, chronology, and degree of privatization in the NHS. Stakeholders have divergent interests, and they use "privatization" as a way to express them, resulting in a Tower of Babel.

**Bohm K., Schmid A., Gotze R., Landwehr C., Rothgang H. (2013). Five types of OECD healthcare systems: Empirical results of a deductive classification. *Health policy*, 113(3):258-69**

Abstract: This article classifies 30 OECD healthcare systems according to a deductively generated typology by Rothgang and Wendt [1]. This typology distinguishes three core dimensions of the healthcare system: regulation, financing, and service provision, and three types of actors: state, societal, and private actors. We argue that there is a hierarchical relationship between the three dimensions, led by regulation, followed by financing and finally service provision, where the superior dimension restricts the nature of the subordinate dimensions. This hierarchy rule limits the number of theoretically plausible types to ten. To test our argument, we classify 30 OECD healthcare systems, mainly using OECD Health Data and WHO country reports. The classification results in five system types: the National Health Service, the National Health Insurance, the Social Health Insurance, the Statist Social Health Insurance, and the Private Health System. All five types belong to the group of healthcare system types considered theoretically plausible. Merely Slovenia does not comply with our assumption of a hierarchy among dimensions and typical actors due to its singular transformation history.

## Technologies médicales / Medical Technologies

**Simon P. (2013). Ressources humaines et télémédecine. *Revue Hospitalière de France*, (554) :**

Abstract: L'utilisation de la télémédecine impose une adaptation des organisations de soins. En modifiant ces organisations, la pratique de la télémédecine impacte directement les ressources humaines. Dans cet article, les ressources humaines en télémédecine sont analysées sous trois

aspects : pratiques professionnelles, nouvelles organisations professionnelles, coopérations entre professionnels de santé.

**Schroeck F.R., Kaufman S.R., Jacobs B.L., Zhang Y., Weizer A.Z., Montgomery J.S., Gilbert S.M., Strope S.A., Hollenbeck B.K. (2013). The Impact of Technology Diffusion on Treatment for Prostate Cancer. *Medical Care*, 51 (12)**

**Abstract:** Background: The use of local therapy for prostate cancer may increase because of the perceived advantages of new technologies such as intensity-modulated radiotherapy (IMRT) and robotic prostatectomy. Objective: To examine the association of market-level technological capacity with receipt of local therapy. Design: Retrospective cohort. Subjects: Patients with localized prostate cancer who were diagnosed between 2003 and 2007 (n=59,043) from the Surveillance Epidemiology and End Results Medicare database. Measures: We measured the capacity for delivering treatment with new technology as the number of providers offering robotic prostatectomy or IMRT per population in a market (hospital referral region). The association of this measure with receipt of prostatectomy, radiotherapy, or observation was examined with multinomial logistic regression. Results: For each 1000 patients diagnosed with prostate cancer, 174 underwent prostatectomy, 490 radiotherapy, and 336 were observed. Markets with high robotic prostatectomy capacity had higher use of prostatectomy (146 vs. 118 per 1000 men, P=0.008) but a trend toward decreased use of radiotherapy (574 vs. 601 per 1000 men, P=0.068), resulting in a stable rate of local therapy. High versus low IMRT capacity did not significantly impact the use of prostatectomy (129 vs. 129 per 1000 men, P=0.947) and radiotherapy (594 vs. 585 per 1000 men, P=0.579). Conclusions: Although there was a small shift from radiotherapy to prostatectomy in markets with high robotic prostatectomy capacity, increased capacity for both robotic prostatectomy and IMRT did not change the overall rate of local therapy. Our findings temper concerns that the new technology spurs additional therapy of prostate cancer.

## Travail et santé / Occupational Health

**Arends I., Bultmann U., Nielsen K., Van Rhenen W., De Boer M.R., Van der Klink J.J.L. (2013). Process evaluation of a problem solving intervention to prevent recurrent sickness absence in workers with common mental disorders. *Social Science & Medicine*, (Ahead of pub)**

**Abstract:** Abstract Common mental disorders (CMDs) are a major cause of sickness absence. Twenty to 30% of the workers who return to work after sickness absence due to CMDs experience recurrent sickness absence. We developed the Stimulating Healthy participation And Relapse Prevention (SHARP)-at work intervention, a problem solving intervention delivered by occupational physicians (OPs), to prevent recurrent sickness absence in this worker population in The Netherlands. A process evaluation was conducted alongside a cluster-randomised controlled trial to (1) evaluate whether the SHARP-at work intervention was implemented according to the protocol and differed from treatment in the control group, and (2) to investigate the relationship between the key elements of the intervention and the effect outcome (i.e. recurrent sickness absence). We collected process data for both the intervention and control group on recruitment, reach, dose delivered, dose received, fidelity, context and satisfaction. Data on recurrent sickness absence was collected through the registry system of the collaborating occupational health service. The study was performed in the Netherlands, and between 2010 and 2012, 154 OPs and 158 participants participated. Compared to the control group, participants in the intervention group more frequently had two or more consultations with the OP (odds ratio [OR] = 3.2, 95% confidence interval [CI] = 1.2 to 8.8) and completed more assignments (OR = 33.8, 95% CI = 10.4 to 109.5) as recommended in the intervention protocol. OPs and participants were satisfied with the intervention and rated it as applicable. Several individual intervention components were linked to the effect outcome. The process evaluation showed that the SHARP-at work intervention was conducted according to the protocol for the majority of the participants and well-

received by OPs and participants. Furthermore, the intervention differed from treatment in the control group. Overall, the results provide support for implementing the intervention in practice.

## Vieillesse / Aging

**Crocker T., Young J., Forster A., Brown L., Ozer S., Greenwood D.C. (2013). The effect of physical rehabilitation on activities of daily living in older residents of long-term care facilities: systematic review with meta-analysis.** *Age and Ageing*, 42 (6) : 682-688.

**Abstract:** Background: the worldwide population is ageing. One expected consequence of this is an increase in morbidity and an associated increased demand for long-term care. Physical rehabilitation is beneficial in older people, but relatively little is known about effects in residents of long-term care facilities. Objective: to examine the effects of physical rehabilitation on activities of daily living (ADL) in elderly residents of long-term care facilities. Methods: systematic review with meta-analysis of randomised controlled trials. We included studies that compared the effect of a physical rehabilitation intervention on independence in ADL with either no intervention or an alternative intervention in older people (over 60 years) living in long-term care facilities. We searched 19 databases including the Cochrane Central Register of Controlled Trials, MEDLINE, EMBASE, CINAHL, AMED, Web of Knowledge and Google Scholar. Two researchers independently screened papers and extracted data. Outcomes of included studies were combined in a standardised mean difference random-effects meta-analysis. Results: thirteen of 14 studies identified were included in the meta-analysis. Independence in ADL was improved by 0.24 standard units (95% CI: 0.11-0.38; P = 0.0005). This is equivalent to 1.3 points on the Barthel Index (0-20 scale). No significant differences in effect were found based on participant or intervention characteristics. Larger sample size and low attrition were associated with smaller estimates of effect. All studies were assessed to be at risk of bias. Conclusions: physical rehabilitation may improve independence for elderly long-term care facility residents, but mean effects are small. It is unclear which interventions are most appropriate.

**Wou F., Gladman J.R.F., Bradshaw L., Franklin M., Edmans J., Conroy S.P. (2013). The predictive properties of frailty-rating scales in the acute medical unit.** *Age and Ageing*, 42 (6) : 776-781.

**Abstract:** Background: older people are at an increased risk of adverse outcomes following attendance at acute hospitals. Screening tools may help identify those most at risk. The objective of this study was to compare the predictive properties of five frailty-rating scales. Method: this was a secondary analysis of a cohort study involving participants aged 70 years and above attending two acute medical units in the East Midlands, UK. Participants were classified at baseline as frail or non-frail using five different frailty-rating scales. The ability of each scale to predict outcomes at 90 days (mortality, readmissions, institutionalisation, functional decline and a composite adverse outcome) was assessed using area under a receiver-operating characteristic curve (AUC). Results: six hundred and sixty-seven participants were studied. Frail participants according to all scales were associated with a significant increased risk of mortality [relative risk (RR) range 1.6-3.1], readmission (RR range 1.1-1.6), functional decline (RR range 1.2-2.1) and the composite adverse outcome (RR range 1.2-1.6). However, the predictive properties of the frailty-rating scales were poor, at best, for all outcomes assessed (AUC ranging from 0.44 to 0.69). Conclusion: frailty-rating scales alone are of limited use in risk stratifying older people being discharged from acute medical units.

**Do Y.K., Norton E.C., Stearns S.C., Van Houtven C. (2013). Informal care and caregivers's health.** *Health Economics*, [Ahead of pub]

**Abstract:** This study aims to measure the causal effect of informal caregiving on the health and health care use of women who are caregivers, using instrumental variables. We use data from South Korea, where daughters and daughters-in-law are the prevalent source of caregivers for frail elderly parents and parents-in-law. A key insight of our instrumental variable approach is that having a parent-in-law

with functional limitations increases the probability of providing informal care to that parent-in-law, but a parent-in-law's functional limitation does not directly affect the daughter-in-law's health. We compare results for the daughter-in-law and daughter samples to check the assumption of the excludability of the instruments for the daughter sample. Our results show that providing informal care has significant adverse effects along multiple dimensions of health for daughter-in-law and daughter caregivers in South Korea.

**Romo R.D., Wallhagen M.I., Yourman L., Yeung C.C., Eng C., Micco G., Perez-Stable E.J., Smith A.K. (2013). Perceptions of Successful Aging Among Diverse Elders With Late-Life Disability. *The Gerontologist*, 53 (6) : 939-949.**

**Abstract:** Purpose: Researchers often use the term "successful aging" to mean freedom from disability, yet the perspectives of elders living with late-life disability have not been well described. The purpose of this study was to explore the meaning of successful aging among a diverse sample of community-dwelling elders with late-life disability. Design and Methods: Using qualitative grounded theory methodology, we interviewed 56 African American, White, Cantonese-speaking Chinese, and Spanish-speaking Latino disabled elders who participate in On Lok Lifeways, a Program of All-inclusive Care for the Elderly. Through semi-structured interviews with open-ended questions, we explored the elders' perceptions of what successful aging and being old meant to them. Results: Despite experiencing late-life disability, most participants felt they had aged successfully. An overarching theme was that aging results in Living in a New Reality, with two subthemes: Acknowledging the New Reality and Rejecting the New Reality. Participants achieved successful aging by using adaptation and coping strategies to align their perception of successful aging with their experiences. Themes were common across race/ethnic groups but certain strategies were more prominent among different groups. Implications: Across race and ethnic groups, most of these participants with late-life disability felt they had aged successfully. Thus, successful aging involves subjective criteria and has a cultural context that is not captured in objective measurements. Understanding elders' perception will help establish common ground for communication between clinicians and elders and identify the most appropriate interventions to help elders achieve and maintain the experience of successful aging.

**Antonio J. (2013). Public opinion and the reform of the pension systems in Europe: the influence of solidarity principles. *Journal of European Social Policy*, 23 (4) : 390-405.**

**Abstract:** The demographic changes that have occurred in European countries in recent decades have made the policies of the public pension system one of the most debated issues of the welfare state. In this paper, I focus on preferences for three pension policy reforms with different distributive consequences: raising contributions, raising the age of retirement, and allowing free choice between public and private pension plans. I use multilevel models to analyse how individual attachment to different solidarity principles (universalistic, conservative, liberal and familistic) affects attitudes toward pension system reforms while controlling for institutional factors. The empirical results strongly support the hypothesis that solidarity principles have a significant influence on individual preferences. I find that individuals who adhere to universalistic or conservative principles are more in favour of increasing contributions in order to maintain the level of pensions, whereas they oppose a postponement of retirement age. In contrast, those who adhere to liberal or familistic principles are against increasing contributions and prefer extending retirement age. The findings at least partially support the  $\alpha$ regime hypothesis, as a more generous pension system appears to increase support for raising contributions while decreasing support for a raise in the age of retirement.

**Dall T.M., Gallo P.D., Chakrabarti R., West T., Semilla A.P., Storm M.V. (2013). An Aging Population And Growing Disease Burden Will Require A Large And Specialized Health Care Workforce By 2025. *Health Aff.(Millwood.)*, 32 (11) : 2013-2020.**

**Abstract:** As the US population ages, the increasing prevalence of chronic disease and complex medical conditions will have profound implications for the future health care system. We projected future prevalence of selected diseases and health risk factors to model future demand for health care services for each person in a representative sample of the current and projected future population. Based on changing demographic characteristics and expanded medical coverage under the Affordable Care Act, we project that the demand for adult primary care services will grow by

approximately 14 percent between 2013 and 2025. Vascular surgery has the highest projected demand growth (31 percent), followed by cardiology (20 percent) and neurological surgery, radiology, and general surgery (each 18 percent). Market indicators such as long wait times to obtain appointments suggest that the current supply of many specialists throughout the United States is inadequate to meet the current demand. Failure to train sufficient numbers and the correct mix of specialists could exacerbate already long wait times for appointments, reduce access to care for some of the nation's most vulnerable patients, and reduce patients' quality of life.